MINISTRY OF HEALTH AND MINISTRY RESPONSIBLE FOR SENIORS

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Office of the Minister of Health and
Minister Responsible for Seniors
Parliament Buildings
Victoria, British Columbia

February 9, 2001

The Honourable Garde Gardom, Q.C.
Lieutenant-Governor of the Province of British Columbia

May it please your Honour:

The annual report of the Ministry of Health and Ministry Responsible for Seniors for 1999/2000 is herewith respectfully submitted.

Corky Evans
Minister of Health and Minister Responsible for Seniors

LEGISLATIVE
VICTORIA BC

Ministry of Health and
Ministry Responsible for Seniors
Parliament Buildings
Victoria, British Columbia

February 9, 2001

The Honourable Corky Evans
Minister of Health and Minister Responsible for Seniors
Victoria, British Columbia

Minister:

I have the honour of submitting the annual report of the Ministry of Health and Ministry Responsible for Seniors for 1999/2000.

Leah Hollins
Deputy Minister

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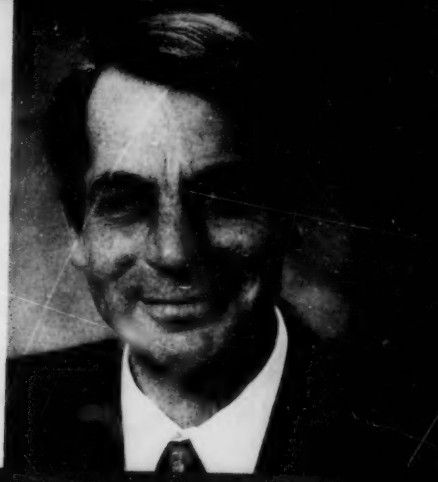


MINISTER'S MESSAGE

This annual report highlights initiatives and achievements of the Ministry of Health and its health care partners in 1999/2000. During the year, the ministry continued to build partnerships and promote innovation to provide accessible, affordable and quality health care services for British Columbians.

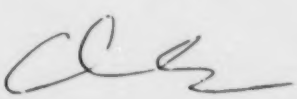
To strengthen the health care system, the provincial government increased health care funding in 1999/2000 for the eighth consecutive year to $8 billion. New initiatives and funding targeted health care priorities including recruiting and retaining more nurses, improving health care facilities, purchasing new equipment and enhancing health services.

During the 1999/2000 fiscal year, new funding provided more surgeries and screening mammography services, and reduced wait lists and wait times. A new wait list registry and Web site were also developed and expanded to include 48 hospitals that perform over 90% of all surgical procedures in B.C.

New funding of $50 million was provided for hiring more nurses in hospitals and long-term care facilities. The ministry also supported Health Match BC in recruiting more health professionals to work in rural and remote communities.

British Columbians were the healthiest of all Canadians according to a 1999 *Maclean's* magazine survey. During 1999/2000, the ministry continued its efforts to promote prevention and wellness. To reduce tobacco use among youth, anti-smoking initiatives such as Kick the Nic quit smoking program and *Gasp* educational magazine were made available at B.C. schools and community agencies. Funding for HIV/AIDS prevention programs and services was also expanded to $10 million, the highest per capita funding in Canada.

The Ministry of Health continues to work with its partners in the health care system to achieve more effective and efficient health care delivery. We are working together to reach our vision of health care – to ensure all British Columbians get the right care, at the right time and in the right place.



Honourable Corky Evans
Minister of Health and Minister Responsible for Seniors

WE ARE WORKING TOGETHER TO REACH OUR VISION OF HEALTH CARE – TO ENSURE ALL BRITISH COLUMBIANS GET THE RIGHT CARE, AT THE RIGHT TIME AND IN THE RIGHT PLACE.

INTRODUCTION

Health care is a top priority for the government and people of British Columbia. The annual report of the Ministry of Health and Ministry Responsible for Seniors is designed to provide valuable information to our health care partners and the public.

The annual report includes three main sections: the ministry's organizational structure, key areas of performance and key events.

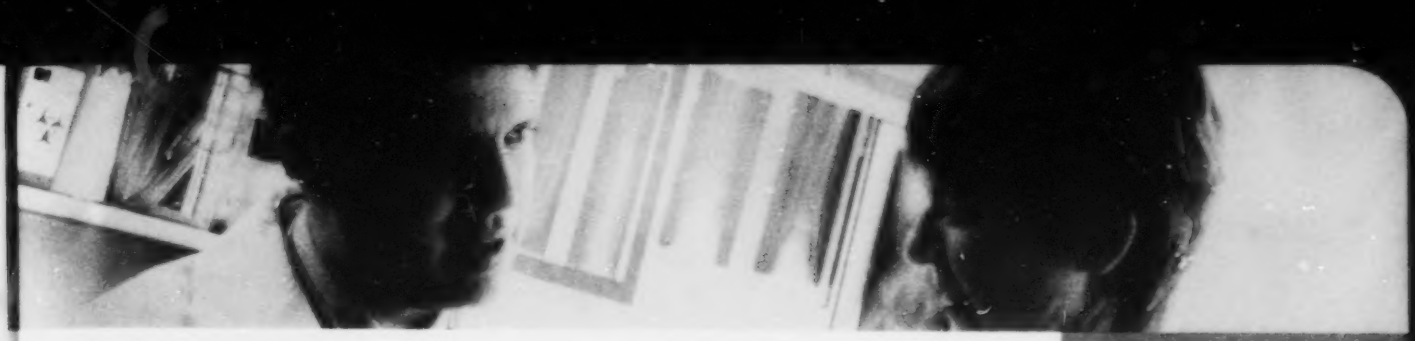
To provide information on the organization of the ministry, there is a brief description of the ministry's structure, program areas and offices.

Another section includes the key areas of performance and specific measures that convey the state of British Columbia's health care system. These performance measures provide a picture of British Columbians' health and health care services supported by the ministry in 1999/2000.

The following section on key events summarizes initiatives, programs and events funded by the ministry during the 1999/2000 fiscal year.

In this report, there is additional information on acts and professions under the jurisdiction of the Minister of Health and Minister Responsible for Seniors, legislative changes passed in 1999, financial statements for the ministry and the organization of health authorities in British Columbia.

HEALTH CARE IS A TOP PRIORITY FOR THE GOVERNMENT AND PEOPLE OF BRITISH COLUMBIA. THE ANNUAL REPORT IS DESIGNED TO PROVIDE VALUABLE INFORMATION TO OUR HEALTH CARE PARTNERS AND THE PUBLIC.



STRATEGIC PLANNING & REPORTING OF HEALTH SERVICES

The Ministry of Health has developed a 1999-2002 Strategic Directions plan, which provides a comprehensive planning and reporting framework for health services in B.C. As the following chart indicates, the ministry's annual report is one of three types of documents that report on progress in achieving the province's health goals. The other two are the annual reports of the Provincial Health Officer and health authorities.

The Planning Framework for Health Services in B.C.

Provincial Health Goals (Government)	Strategic Plan (Ministry of Health)	Health Services Plans (Health Authorities)
Provincial Health Officer's (PHO) Annual Report	**Ministry of Health (MOH) Annual Report**	**Health Authority (HA) Annual Reports**
Reports on population health using social determinants of health and vital statistics by: Identifying – PHO Collecting – HA, External Analyzing – MOH Reporting – PHO	Reports on system performance using selected key indicators from existing ministry data bases by: Identifying – MOH Collecting – HA/MOH Analyzing – MOH Reporting – MOH	Reports on health authority progress in achieving principles of health reform using selected appropriate measures by: Identifying – HA with MOH Collecting – HA Analyzing – HA Reporting – HA for HA (MOH for province)

The People of British Columbia

Source: Strategic Directions for British Columbia's Health Services System. 1999.

MINISTRY MISSION STATEMENT

The mission of the Ministry of Health is to support British Columbians in their efforts to maintain and improve their health. The ministry provides strategic direction and leadership of the health care system on behalf of the provincial government. Through a broad range of programs, services and public funding, the ministry is responsible for ensuring the maintenance of high quality, accessible, affordable health care for British Columbians.

STRUCTURE OF THE HEALTH CARE SYSTEM

In Canada, the federal government has established legislation, such as the *Canada Health Act* and the *Food and Drug Act*, to define the roles and responsibilities of governments in our health care system. The federal government provides health care funding support to the provinces and regulates the safety of food, drugs, medical devices and other health products. In addition, the federal government has responsibility for aspects of surveillance and public health.

Similar to other provinces, British Columbia has responsibility for the funding and delivery of health care services by providers throughout the province. These services include wholly and partially funded health services, as well as services regulated but not funded by the government.

British Columbia has a progressive and integrated health care system based on regional delivery and self-regulating professional colleges, providing quality, accessible, affordable and sustainable health care. Although the Ministry of Health has the authority and responsibility to legislate and administer the province's publicly-funded health care system, the health authorities are responsible for the delivery and management of services in their communities. The health authorities include 11 Regional Health Boards, 34 Community Health Councils, and seven Community Health Services Societies across the province.

The regional structure of B.C.'s health care system is outlined in maps included in appendices to this report:

- Regional Health Boards (see Appendix 7, page 78)
- Community Health Councils (see Appendix 8, page 79)
- Community Health Services Societies (see Appendix 9, page 80)

BRITISH COLUMBIA HAS A PROGRESSIVE AND INTEGRATED HEALTH CARE SYSTEM BASED ON REGIONAL DELIVERY AND SELF-REGULATING PROFESSIONAL COLLEGES, PROVIDING QUALITY, ACCESSIBLE, AFFORDABLE AND SUSTAINABLE HEALTH CARE.

STRUCTURE OF THE MINISTRY

The following is a description of the Ministry of Health by areas of responsibility as of March 31, 2000.

REGIONAL PROGRAMS

Regional Programs consists of Regional Operations, Public and Preventive Health, Continuing Care Plan Implementation, Adult Mental Health Plan Implementation, and Strategic Liaison. In 1999/2000, Regional Programs was reorganized to strengthen the integration of services and to support health authorities in managing health service delivery, according to policies and guidelines established by the Ministry of Health. The British Columbia Ambulance Service reports to the Associate Deputy Minister of Regional Programs, who serves as the Chair of the Emergency Health Services Commission.

Regional Operations

Regional Operations provides funding, policy direction and support to health authorities for the delivery of health services in institutional and community settings, including adult mental health and other community-based programs. The division's mandate is to ensure a coordinated delivery system for acute, specialized, tertiary continuing and community care that provides all B.C. residents with reasonable access to necessary health care services of appropriate quality at an affordable and sustainable cost.

Regional Operations consists of regional teams, which are responsible for supporting health authorities in specific geographic areas of the province. Regional teams are supported by a policy group and work with other divisions within the ministry as required. The regional teams also collaborate with health authorities, service providers, industry and other stakeholders in developing policy, operating standards, accountability structures, monitoring and evaluation procedures for health services.

Tertiary Programs and Provincial Priorities provide funding for care that is only available in facilities that have highly-trained specialists and specialized equipment. Tertiary facilities have sufficient volume of cases, patients and procedures to provide competent, effective care.

In 1999/2000, Regional Operations supported Regional Health Boards, Community Health Councils and Community Health Services Societies in their health services planning. This year, health authorities commenced their planning process. Regional Health Boards developed and submitted their first health service plans. The regional teams review, approve and monitor the implementation of the plans. Health service plans are based on assessed priority health needs and demonstrate how health authorities propose to meet those needs.

THE DIVISION'S MANDATE IS TO ENSURE A COORDINATED DELIVERY SYSTEM FOR ACUTE, SPECIALIZED, CONTINUING AND COMMUNITY CARE THAT PROVIDES ALL B.C. RESIDENTS WITH REASONABLE ACCESS TO NECESSARY HEALTH CARE SERVICES OF APPROPRIATE QUALITY AT AN AFFORDABLE AND SUSTAINABLE COST.

Health authorities are required to manage and deliver services, submit and maintain a balanced budget, and report on performance and progress in accordance with their approved plans.

Public and Preventive Health

Public and Preventive Health provides leadership and policy development to enable individuals and communities to achieve and maintain environments free of health and safety hazards, ensure the well being of people living in licensed community care facilities, and achieve a healthier society through the prevention and control of disease.

Public and Preventive Health provides the management and operation of public and preventive health programs of the ministry, including: Program Support and Accountability, Public Health Protection, Community Care Facilities, Aboriginal Health, Radiation Protection, Preventive Health, HIV/AIDS and Tobacco Strategy. Public and Preventive Health also oversees the management and operation of the British Columbia Centre for Disease Control Society.

The **Program Support and Accountability Branch** provides leadership in public health through strategic and business planning, policy development, regional accountability, information and analysis, and program support. It establishes an accountability framework for health authorities for the delivery of public health programs in British Columbia.

The **Public Health Protection Branch** provides advocacy and leadership in developing and managing strategies to minimize environmental health and safety risks to the public. It is responsible for the development and implementation of legislation, policies and standards to prevent disease from unsanitary practices and from exposure to environmental hazards. Legislation includes the *Health Act*, *Milk Industry Act*, *Fish Inspection Act*, and the *Meat Inspection Act* and Regulations pursuant to these Acts.

The **Community Care Facilities Branch** is responsible for developing and implementing legislation, policy and guidelines to promote the health of persons cared for in licensed care facilities. The legislative authority is derived from the *Community Care Facility Act*, Adult Care Regulations and Child Care Licensing Regulation. Community Care Facilities programs are administered locally by Medical Health Officers and Licensing Officers who are responsible for service delivery in the province.

The **Aboriginal Health Division** has primary responsibility for providing advice, support and assistance on aboriginal health and policy direction. The division is responsible for strengthening the ministry's relationships with aboriginal communities through negotiation, consultation and contract management. Its mission is to improve the health status of aboriginal people by improving access to health care, increasing control and decision making by aboriginal people, and building relationships with aboriginal communities, health partners, provincial ministries and federal departments.

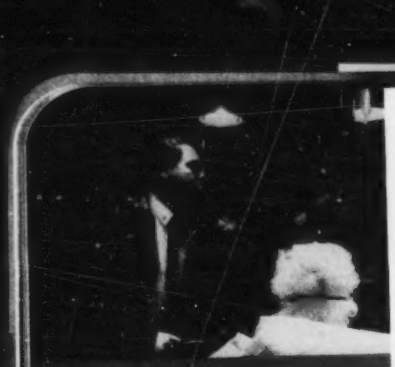
The **Radiation Protection Branch** provides expertise and leadership regarding health hazards and risks associated with radiation exposure. Its main responsibility is to develop and implement effective protection and prevention initiatives for the benefit of patients, workers and the public.

The **Preventive Health Branch** plans, develops and evaluates provincial initiatives and personal health care strategies, policies and standards to prevent illness or injury and to promote the health and well-being of British Columbians.

The **HIV/AIDS Division** provides leadership and funding for a range of HIV/AIDS services in communities throughout the province. The division administers grants to almost 50 HIV/AIDS organizations to provide community-based services, including needle exchange services, street outreach programs, services for youth, women and ethnic minorities, and programs providing food, housing, hospice and respite care for people living with HIV/AIDS and their caregivers. The HIV/AIDS Division leads the implementation of *British Columbia's Framework for Action on HIV/AIDS*, which outlines principles, objectives, roles, responsibilities and initiatives in addressing the HIV/AIDS epidemic. This includes inter-ministerial discussion and action on HIV/AIDS and implementation of the *Framework* in coordination with *The Red Road: Pathways to Wholeness, a British Columbia Aboriginal AIDS Strategy* and the *Canadian Strategy on HIV/AIDS*.

The **Tobacco Strategy Branch** provides leadership and strategic planning on tobacco issues impacting British Columbians. The main goals of B.C.'s tobacco strategy are to increase awareness of and protect youth from the harmful effects of tobacco, monitor and regulate the tobacco industry, and hold the industry accountable for damages caused. The ministry is active in providing British Columbians, especially youth, with tools and information to protect themselves from the dangers of tobacco.

IMPROVING THE HEALTH STATUS OF ABORIGINAL PEOPLE BY IMPROVING ACCESS TO HEALTH CARE, INCREASING CONTROL AND DECISION MAKING BY ABORIGINAL PEOPLE, AND BUILDING RELATIONSHIPS WITH ABORIGINAL COMMUNITIES, HEALTH PARTNERS, PROVINCIAL MINISTRIES AND FEDERAL DEPARTMENTS.



The **British Columbia Centre for Disease Control** is funded by Public and Preventive Health, and operated by a society under governance of the Vancouver/Richmond Health Board. The centre coordinates the prevention and control of reportable communicable disease as specified by the *Health Act*, *Venereal Diseases Act* and Communicable Disease Regulation. It maintains registries and reports on communicable disease in the province. The centre also develops and recommends policy and procedures for the prevention, control surveillance and elimination of communicable disease.
In addition, it provides diagnostic clinical services, referral laboratory testing and pharmaceutical services, and arranges for the distribution of vaccines in B.C. Specific program services include Sexually Transmitted Disease (STD/AIDS) Control, Tuberculosis Control, Laboratory Services, Epidemiology Services and Pharmacy.

STRATEGIC INITIATIVES

The **Continuing Care Plan Implementation Unit** is responsible for developing and implementing a plan to renew continuing care services in British Columbia, based on a comprehensive review launched by the Ministry of Health in spring 1998.

Adult Mental Health Plan Implementation is responsible for policy support, funding and monitoring the delivery of mental health services in British Columbia. The division's mandate is to support health authorities, government partners and mental health agencies in their efforts to reduce the impact of serious mental illness on individuals, families and communities.

The **Strategic Liaison Division** provides leadership in the development and implementation of processes and protocols for stakeholder relations and corporate issues management. The office is responsible for facilitating constructive approaches to relationships and partnerships, increasing understanding of and confidence in the health care system.

The British Columbia Ambulance Service

The British Columbia Ambulance Service provides public ambulance service in the province and reports to the Emergency Health Services Commission. Approximately 3,300 employees provide emergency and non-emergency ambulance responses to over 415,000 calls and perform more than 6,300 aeromedical evacuations each year.

Service is provided through 198 ambulance stations, three regional dispatch centres, an air ambulance dispatch centre and four regional administrative offices, in addition to provincial headquarters in Victoria.

STRATEGIC PLANNING/ PHARMACARE

Strategic Planning/Pharmacare includes the following programs and services: Pharmacare, Strategic Planning and Health Human Resources, Office for Seniors, Policy Development and Project Management, Women's Health Bureau and Intergovernmental Relations.

The **Pharmacare Program** assists B.C. residents with the cost of prescription medication, permanent prosthetic appliances, designated children's orthotic devices, home oxygen and other medical supplies. The program administers benefits through eight different plans. The largest plans are those for seniors, income assistance recipients and the general public. Pharmacare provides advice to government on federal regulation of prescription medication and the pricing of pharmaceuticals. It also works with professional colleges to encourage appropriate use of prescription medication.

The **Strategic Planning and Health Human Resources Division** is responsible for ministry-wide planning and reporting processes, including working with partners to develop plans for the health services system. Specific areas of responsibility include human resources planning, performance planning, strategic planning and health services planning.

The **Office for Seniors** is a focal point within the government for issues of concern to B.C. seniors and provides administrative support to the Minister Responsible for Seniors. In addition, the office provides administrative and research support to the Seniors' Advisory Council, provides information to the public regarding benefits for seniors, monitors and collaborates on policy and program development across government, and coordinates the activities of Senior Citizen Counsellors throughout the province. An important function of the Office for Seniors is to promote positive attitudes about aging and elderly people.

The **Policy Development and Project Management Division** is responsible for the development, coordination and review of policy initiatives in consultation with other program areas, ministries and stakeholders. In addition, the division manages cross-ministerial issues including child health, immigration and special projects.

The primary function of the **Women's Health Bureau** is to assist the ministry in developing a health care system that is sensitive to the unique needs of women. Bureau staff work within government and liaise with community groups and health care providers to enhance understanding of women's health care issues. They also work with other ministries to address the broader social and economic needs of women. As well, the bureau acts as a secretariat to the Minister's Advisory Council on Women's Health.

The **Intergovernmental Relations Division** provides services to fulfill the ministry's mandate by coordinating activities within the ministry, between ministries and with other governments. Services include developing policy and providing support for federal, provincial and territorial meetings of ministers and deputy ministers of health. The division provides project management, research analysis and advice on a broad range of intergovernmental issues. The division is also responsible for the ministry's multiculturalism initiatives and annual multiculturalism report. A key service of the division is events coordination for major meetings and conferences, including teleconferencing.

THE OFFICE FOR SENIORS IS A FOCAL POINT WITHIN THE GOVERNMENT FOR ISSUES OF CONCERN TO B.C. SENIORS.

THE SUPPLEMENTARY BENEFITS PROGRAM PROVIDES COVERAGE FOR THE MOST COMPREHENSIVE RANGE OF SUPPLEMENTARY HEALTH CARE SERVICES AVAILABLE IN CANADA.

MEDICAL SERVICES PLAN

The Medical Services Plan is the mandatory medical insurance plan for the residents of British Columbia. It provides reimbursement for all medically required services by physicians and for diagnostic facilities according to the schedule of fees approved by the Medical Services Commission. The plan also provides alternative payment arrangements to physicians working on contract, salaried or sessional arrangements. In addition, the Medical Services Plan provides incentives to physicians in rural areas and travel assistance to visiting specialists. The Medical Services Plan also pays for disability insurance for physicians and contributes to physicians' Contributory Professional Retirement Savings Plan, Canadian Medical Protective Association premiums, and Continuing Medical Education fund.

The **Medical Services Commission** is established under the authority of the *Medicare Protection Act*. The nine-member commission consists of three representatives each from the British Columbia Medical Association, the government and the public. The aim of the Medical Services Commission is twofold: to ensure reasonable access to quality medical, health and diagnostic services, and to develop more effective and affordable methods of managing the services under the Medical Services Plan.

The **Strategic Development and Planning Division** is responsible for informational and economic analysis and development for the Medical Services Plan. It also provides negotiations support, utilization management services, alternative payment arrangements, administration and policy direction. The division oversees the northern and rural program, and public and professional education and information.

The primary function of the **Operations Division** is to administer the province's medical insurance plan by registering beneficiaries, billing premiums and arranging payments for services. This includes providing a premium assistance program for British Columbians with low incomes. The division also monitors professionals' patterns of practice, investigates misuse of the medical insurance plan, and participates in practitioner fee negotiations.

The **Supplementary Benefits Program** provides coverage for the most comprehensive range of supplementary health care services available in Canada, including chiropractic, dental surgery, massage therapy, naturopathy, optometry, physical therapy and podiatry. With the exception of dental surgery, the province provides funding for these services without cost sharing by the federal government.

CORPORATE PROGRAMS

Corporate Programs provides central operational support services to the ministry. Its primary function is to provide program areas with expertise and leadership in human resources, information management and technology, information and privacy, legislation and professional regulation, and emergency preparedness. In addition, Corporate Programs represents the ministry in its dealings with central agencies of government, including the Public Service Employee Relations Commission, the Provincial Emergency Program and Information, Science and Technology Agency.

Finance and Management Services provides financial, administrative and management services to program areas to support program delivery, including payroll, revenue collection, payment processing, budget development, and auditing claims by medical practitioners and pharmacies. The division is responsible for the development, implementation and operation of the ministry's fiscal management and control systems.

The **Legislation and Professional Regulation Division** is responsible for ensuring that the ministry's legislative requirements are met. This includes the development of new legislation, the amendment of existing legislation, and the preparation of regulations and orders-in-council. The division also oversees the regulation of health professions and works with 21 professional colleges on governance issues. In addition, the division supports the work of the Health Professions Council and provides administrative support to the Review Panels under the *Mental Health Act* and to appeal boards under other Acts.

The **Human Resources Division** provides advice and direction on all human resource matters within the ministry including recruitment, selection and placement of staff, compensation and classification, staff development and training, human resource planning, employment equity, labour relations, organizational development, and occupational safety and health.

The **Information and Privacy Branch** is responsible for the government's legislative commitment to make public bodies more accountable and to protect personal privacy in accordance with the *Freedom of Information and Protection of Privacy Act* (*FOIPP Act*). Key functions of the branch include assisting the public to access ministry records, ensuring confidentiality of personal information, and providing policy advice to program areas within the ministry. The branch also provides consultation and training to ministry staff, health authorities and health organizations on interpreting the *FOIPP Act*.

The **Emergency Preparedness Branch** is responsible for preparing the ministry to meet its obligations under the *Emergency Program Act*. Its mission includes working with health care providers to prepare the provincial health care system to respond to and recover from any disaster that may threaten the health of British Columbians.

INFORMATION MANAGEMENT GROUP

The Information Management Group, under the direction of the ministry's Chief Information Officer, provides province-wide information management strategies, initiatives, standards and policies for the health care system. It also provides and maintains the information and technology infrastructure that supports the ministry's business functions.

The Information Management Group has the following branches: Client Services, Information and Technology Services, HealthNet/BC and the Year 2000 Office. The Vital Statistics Agency also reports to the Chief Information Officer.

Client Services Branch is responsible for the planning and coordination of the ministry's information management and technology services. Client Services works with ministry program areas to determine business requirements, conduct feasibility analysis, and develop and implement solutions. The branch is also responsible for the ministry's Web services, research library and records management.

Information and Technology Services Branch provides the infrastructure, network services and technological solutions for the ministry's office and information systems.

HealthNet/BC Branch coordinates the development of the infrastructure for electronically linking the health sector. This division is responsible for setting standards and policy for health data and technology, including coordination with national standards organizations and jurisdictions. It manages all significant projects undertaken by the Information Management Group. HealthNet/BC also coordinates consultation with health care partners, such as professional colleges and health authorities.

The **Year 2000 Office** was established in 1998 to ensure that the Ministry of Health and health authorities continued to deliver quality services, and to ensure that public health was not affected by Year 2000 compliance issues. The role of the office included leading, coordinating and implementing Year 2000 compliance processes to mitigate technical concerns. In addition, the office led the establishment of the provincial and Canadian Year 2000 Clearinghouse for Health, providing a central repository for reporting and disseminating information for health authorities and other jurisdictions.

The **Vital Statistics Agency** is responsible for the registration and certification of all vital events in the province under the authority of the *Vital Statistics Act*, *Marriage Act* and *Name Act*. The agency also maintains the Wills Registry and Health Status Registry under sections of the *Wills Act* and *Health Act*. In addition, Vital Statistics publishes a wide range of data on vital events and health indicators in its annual report, quarterly digest and other publications. As a special operating agency since 1996, its activities and achievements are outlined in the annual *Financial and Performance Report*.

COMMUNICATIONS AND ISSUES MANAGEMENT

Communications and Issues Management is responsible for overall planning, implementation and evaluation of the ministry's communications activities. The branch consists of the Executive Director's office, Corporate Communications, and Issues Management and Media Relations. Services provided by the branch include issues management, communications project planning and management, media and public relations, advertising, and the development and execution of a wide range of health education and prevention initiatives.

OFFICE OF THE PROVINCIAL HEALTH OFFICER

The Office of the Provincial Health Officer is legislated by the *Heath Act* to report independently to the Minister of Health, the ministry and the public on health issues in British Columbia. The functions of this office include advising on health issues, producing an annual report on the health of the population, reporting on progress toward the government's health goals, and assisting the ministry with issues management and program and policy development. The office also works with the British Columbia Centre for Disease Control and the Medical Health Officers to fulfill the legislated health protection and disease control mandate, chairing the minister's Communicable Disease Policy Committee and serving as a member of the Federal, Provincial and Territorial Advisory Committee on Population Health.

THE OFFICE OF THE PROVINCIAL HEALTH OFFICER IS LEGISLATED BY THE *HEATH ACT* TO REPORT INDEPENDENTLY TO THE MINISTER OF HEALTH, THE MINISTRY AND THE PUBLIC ON HEALTH ISSUES IN BRITISH COLUMBIA.

KEY AREAS OF PERFORMANCE

Why Measure Performance?

In this annual report, the Ministry of Health provides extensive information on the performance of our publicly funded health care system. Tracking and reporting this information is consistent with the ministry's increasingly strategic approach. The ministry has a strong commitment to ensuring British Columbians get the greatest possible health benefit for every tax dollar devoted to health care. This report presents a diverse selection of performance measures for several reasons, including:

- People care – British Columbians want to ensure health services will be available for them and those they care about when they need them. Performance measurement is one way to keep track of the quality, accessibility and delivery of these services.
- Increases learning – By measuring performance across the province, it's possible to learn from the experience of those who are achieving success. Performance measurement helps us learn and share good ideas.
- It is essential to strategic planning – Strategic planning involves using resources in ways that generate the best possible results for every dollar spent. Performance measurement helps to determine if specific initiatives are effective, and to adjust if there are better ways to achieve our province's health goals.

How Do We Measure Performance?

It isn't always easy to measure performance, mainly because there are multiple factors that contribute to health outcomes. However, the performance of our health care system can be measured to the extent it achieves specific objectives. First and foremost, it must improve the health of British Columbians by preventing illness and premature death, relieving pain and suffering, and improving quality of life.

A STRONG COMMITMENT TO ENSURING BRITISH COLUMBIANS GET THE GREATEST POSSIBLE HEALTH BENEFIT FOR EVERY TAX DOLLAR DEVOTED TO HEALTH CARE.

PROVINCIAL HEALTH OFFICER'S REPORTS

SINCE 1993, THE PROVINCIAL HEALTH OFFICER HAS BEEN REQUIRED BY THE *HEALTH ACT* TO REPORT ANNUALLY TO BRITISH COLUMBIANS ON THEIR HEALTH STATUS AND ON THE NEED FOR POLICIES AND PROGRAMS THAT WILL IMPROVE THEIR HEALTH. SOME OF THE REPORTS PRODUCED TO DATE HAVE GIVEN A BROAD OVERVIEW OF HEALTH STATUS, WHILE OTHERS HAVE FOCUSED ON PARTICULAR TOPICS SUCH AS WOMEN'S HEALTH, CHILD HEALTH, INJECTION DRUG USE, AND IMMUNIZATION.

PROVINCIAL HEALTH OFFICER'S REPORTS ARE ONE MEANS OF REPORTING ON PROGRESS TOWARD THE PROVINCIAL HEALTH GOALS, WHICH WERE ADOPTED BY THE PROVINCE IN 1997. COPIES OF THE PROVINCIAL HEALTH OFFICER'S REPORTS AND THE DOCUMENT, HEALTH GOALS FOR BRITISH COLUMBIA, ARE AVAILABLE FROM THE OFFICE OF THE PROVINCIAL HEALTH OFFICER.

Performance Measures for 1999/2000

This section presents performance measures to illustrate the state of B.C.'s publicly funded health care system. The Ministry of Health will continue to report and provide this information in future years, allowing comparisons over time. These performance measures will be revised and expanded in the future.

This section is divided into four key areas:

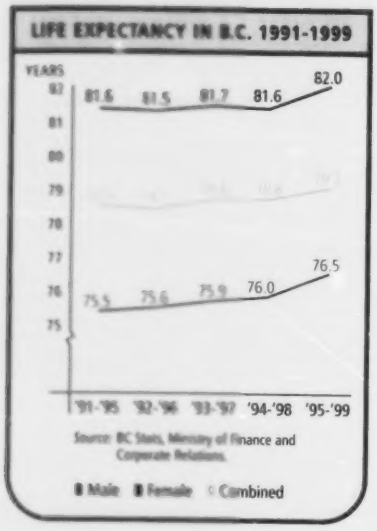
- Overall health – Measurement in areas that indicate the overall health of British Columbians in 1999/2000.
- Accessibility – Measurement showing the extent to which British Columbians were able to access health services that they needed.
- Quality – Measurement in areas that indicate the quality of health services.
- Perspectives on health spending – Measurement of the amount spent on health care and the success of initiatives, helping ensure health spending is cost-effective.

OVERALL HEALTH

The following indicators provide a snapshot of British Columbians' health in 1999/2000. International research over the past 20 years has shown that a population's health is influenced by a number of factors outside the health care system, such as level of income and education. Publications such as the *Provincial Health Officer's Annual Report* and the *Vital Statistics Annual Report* provide more detailed information on health status, including improvements in individual health, decrease in sickness and extension of life expectancy.

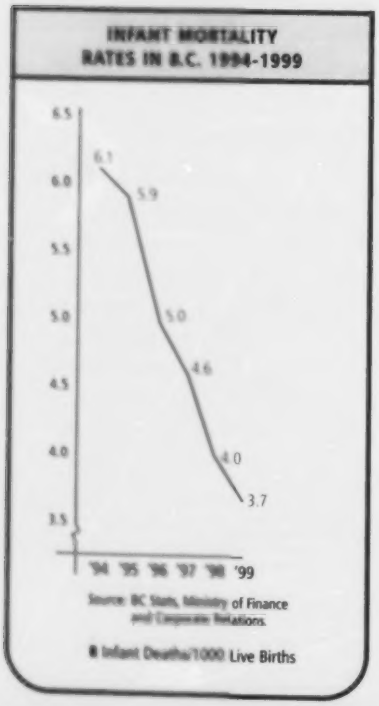
Life Expectancy

British Columbians are among the healthiest people in the country and the world. Our level of health continues to improve, although there are disparities due to income and other factors. Overall life expectancy has reached 76.5 years for men and 82.0 years for women.



Infant Mortality

The infant mortality rate, an internationally accepted measure of population health, reached a record low of 3.7 per 1,000 population in 1999 in B.C. For the province overall, fewer infants are dying in the first year of life. Early deaths due to heart disease, injuries and other preventable causes also continue to decline.



However, differences in health status persist among groups and communities in B.C. On average, infants who live in areas with lower incomes have up to twice the risk of dying before their first birthday, compared to infants in other areas of the province. This is reflected in higher rates of infant mortality among Aboriginal infants and infants born in northern areas and parts of Vancouver. Improvements must take place if all regions and population groups are to achieve the high level of health enjoyed by the healthiest groups.

Unintentional Injuries

Up to 90 per cent of injuries are preventable if proven prevention methods are fully implemented. In 1997, the Minister's Injury Prevention Advisory Committee developed injury prevention objectives and targets for children and youth age 0-24 for whom unintentional injuries are the leading cause of death.

If current trends continue, the year 2001 targets for reductions in injury hospitalizations and deaths will be reached. Too many preventable injuries still occur, especially among children and youth, seniors, males, Aboriginal people, and people living in northern and rural parts of the province.

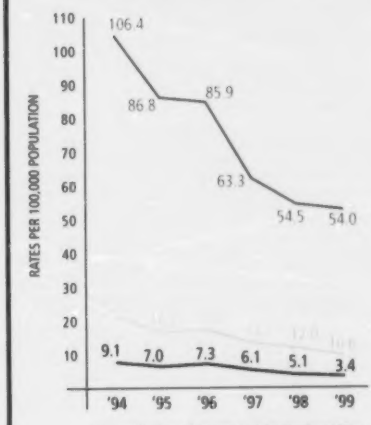
THE INFANT MORTALITY RATE, AN INTERNATIONALLY ACCEPTED MEASURE OF POPULATION HEALTH, REACHED A RECORD LOW IN B.C. IN 1999.

Incidence of HIV

Overall, the rate of new HIV infections has been declining, in part due to reduction of transmission among men who have sex with men and harm reduction measures targeted at injection drug users. In 1995, injection drug users became the group with the highest number of positive HIV tests. Although the epidemic of HIV among injection drug users appears to have peaked, this group still accounts for about 40 per cent of the new HIV infections recorded. Aboriginal people make up approximately 15 per cent of those testing newly positive for HIV.

Vancouver has the highest rates of HIV infections, although new positive cases occur in all areas of the province. HIV can be controlled through prevention programs and harm reduction strategies aimed at high-risk communities. Harm reduction strategies are practices that aim to decrease the negative personal, social and economic consequences of inappropriate activities such as drug use. These initiatives can be complemented by providing access to drug treatments and taking action to address the underlying factors that place people at increased risk of HIV infection.

PERSONS TESTING NEWLY POSITIVE FOR HIV BY HEALTH JURISDICTION, RATES PER 100,000 POPULATION, B.C. 1994-1999



Source: Number of persons testing newly positive from STD/AIDS Control, BC Centre for Disease Control Society, HIV/AIDS Update: Year End 1999. Table 2.14, pp. 36-37. Population estimates from BC Stats.

■ Vancouver ■ Rest of BC ■ BC Total

Food and Waterborne Diseases

Intestinal diseases such as salmonellosis, giardiasis (beaver fever), and E. coli are usually caused by consuming contaminated food or water. The extent of these illnesses is not known precisely because most cases are not recognized or reported. As well, the source of the infection is not always known.

Based on the data we have, we know that British Columbians contract food and waterborne illnesses within the province or while travelling. Food and waterborne infections can be prevented through water treatment, watershed management, and promotion of safe food handling and storage practices. Hand washing is a simple and effective way to prevent the spread of intestinal diseases.

Tobacco Use

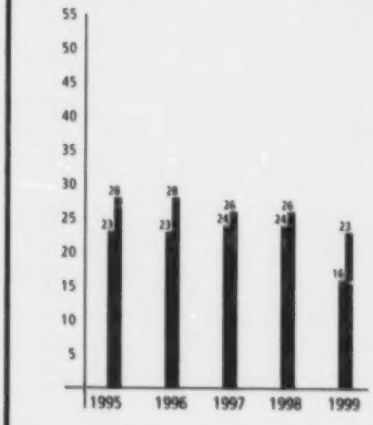
Tobacco use is the most important preventable cause of illness and death in industrial countries. Since the 1960s, the smoking rate in British Columbia has dramatically decreased from almost 50 per cent of all adults using tobacco products to 20 per cent, the lowest smoking rate in the country. Twenty-nine per cent of young adults smoke, most of whom started before their nineteenth birthday. British Columbia's tobacco strategy aims to protect young people from starting to use tobacco, change the behaviour of the tobacco industry, and to hold the tobacco industry accountable for the damage its products have caused. This will be achieved through an integrated approach consisting of public education initiatives, legislation and legal action.

Provincial funding for tobacco reduction programs increased from $5 million to $6.5 million in 1999/2000. The Ministry of Health works closely with public health partners and health authorities to implement a range of prevention, cessation and protection projects.

New initiatives, such as prevention resources for Grades K-7 (bc.tobaccofacts), have been distributed to schools throughout the province. The ministry has also developed the Kic the Nic program to help youth stop smoking, in consultation with B.C. teens. For the second year, students nominated from across the province have been appointed to the B.C. Teen Tobacco team. This team advises the Minister of Health on tobacco issues and provides leadership on tobacco initiatives in their communities. Their first report, *Speaking Out*, was published in the summer of 1999. In January 1999, the ministry launched the first edition of *Gasp* magazine and distributed it to all grade 8 and 9 students in the province. *Gasp* magazine uses personal stories, graphic photographs, quizzes, and information on cigarette contents and tobacco industry practices to motivate students to avoid tobacco.

TOBACCO USE IS THE MOST IMPORTANT PREVENTABLE CAUSE OF ILLNESS AND DEATH IN INDUSTRIAL COUNTRIES.

SMOKING RATES, AGES 15 AND OLDER, B.C., 1995 – 1999



Source: Provincial Health Officer's Annual Report, B.C., 1999

THE B.C. GOVERNMENT HAS COMMITTED ITSELF TO ADDRESSING THE THREE FACTORS THAT DEFINE ACCESSIBILITY: GEOGRAPHIC ACCESS, FINANCIAL ACCESSIBILITY AND WAITING TIMES.

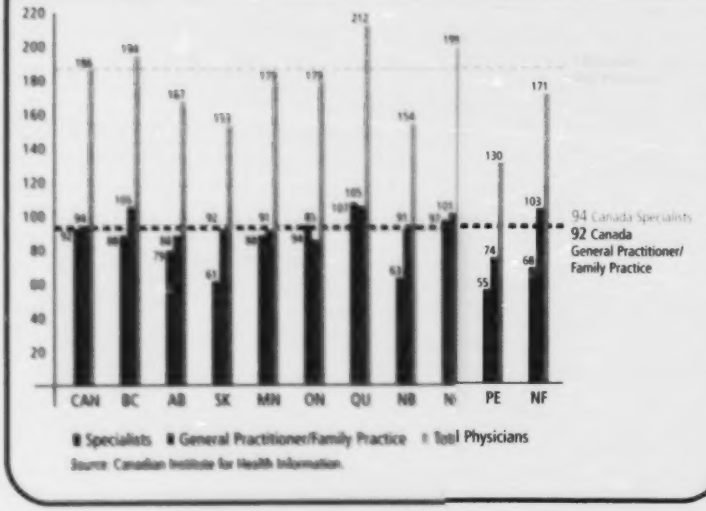
In August 1999, the *Tobacco Sales Act* was amended to require publication of suspensions issued to retailers convicted of two or more offenses under the Act. The *Tobacco Sales Act* prevents the sale of tobacco to persons under the age of 19.
In October 1999, the tobacco companies challenged the *Tobacco Damages and Health Care Costs Recovery Act*. In February 2000, Justice Ronald Holmes of the Supreme Court of British Columbia upheld four principles of the Province's legislation. However, the court struck down the Act because of extraterritorial provisions the judge ruled were beyond the Province's jurisdiction.
The ministry intends to re-introduce the legislation without the extraterritorial provisions to re-launch the litigation.

ACCESSIBILITY

All British Columbians should receive health services that help them achieve the best possible health. Health services should be available when and where they are needed, without financial barriers.

Accessibility is one of the fundamental principles of Canada's health care system. The federal government's *Canada Health Act* and the B.C. government's *Medicare Protection Act* both guarantee British Columbians ready access to physician and hospital services when they need them. Improving access to other health services has also been a priority of the B.C. government, which has committed to addressing the three factors that define accessibility: geographic access, financial accessibility and waiting times.

PHYSICIANS PER 100,000 POPULATION BY PHYSICIAN TYPE & PROVINCE, 1999



Source: Canadian Institute for Health Information.

The performance indicators in this report have been selected to provide overall trends and an illustration of health care accessibility in 1999/2000. Both accessibility and quality of health services are closely linked and discussed in this report.

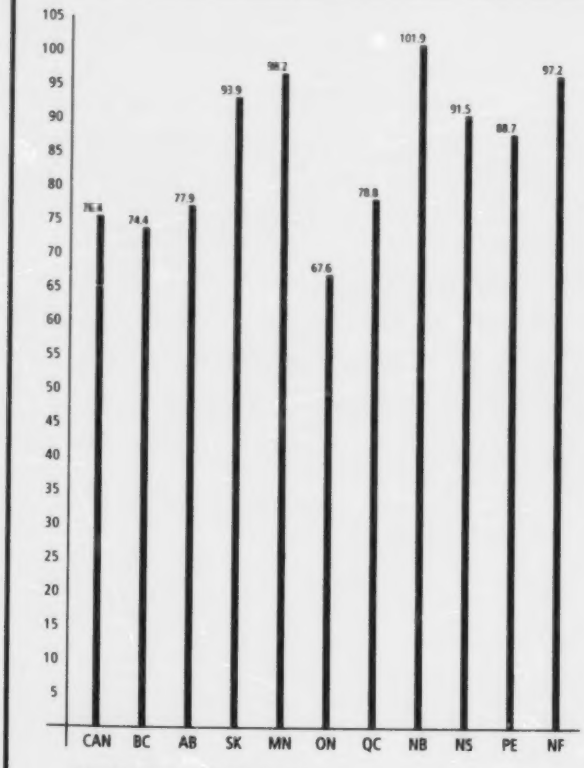
The measures presented here provide an overall picture of health service accessibility. The introduction to each section describes limitations of using certain measures.

Human Resources

An adequate supply of qualified health professionals, such as doctors and nurses, is essential for good access to care. While higher numbers might seem to indicate better accessibility to health services, this isn't always the case. There are two key limitations to using human resource data as indicators of accessibility:

- Province-wide information doesn't show variations from one part of the province to another. Generalizations based on province-wide numbers are of limited value.

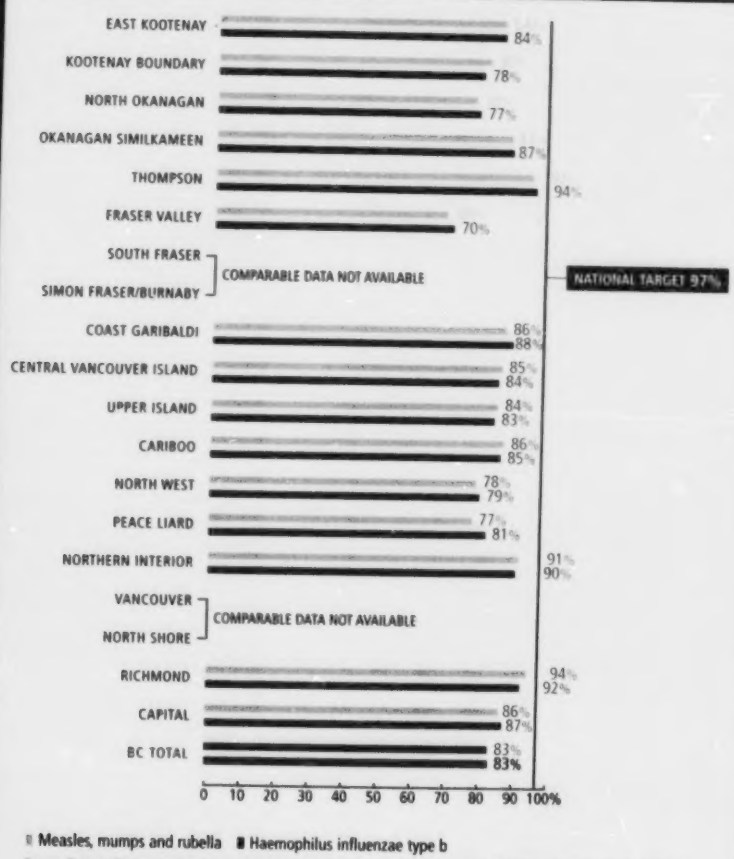
REGISTERED NURSES AND REGISTERED PSYCHIATRIC NURSES PER 10,000 POPULATION BY PROVINCE, 1999



Source: Supply and Distribution of Registered Nurses in Canada, 1999, Canadian Institute for Health Information 2000 and communication from the College of Registered Psychiatric Nurses.

- Larger numbers of a particular type of health professional do not necessarily lead to better health. Oversupply can be as much of a problem as undersupply, since it can create pressure to devote more health resources to an area that might contribute less to improving health than a similar expenditure in another area of the health system.

B.C. IMMUNIZATION RATES FOR CHILDREN 24 MONTHS OF AGE, 1999
(BY HEALTH AUTHORITY)



Source: Report of Immunization Status of Child Health Records born in April 1997. B.C. Ministry of Health Administrative Circular No. 99:003.

While views differ on what represents an adequate supply of any given profession, the figures presented here indicate that, overall, British Columbia is well supplied with physicians in comparison with the rest of Canada. In 1999, British Columbia had the third highest number of physicians for the size of our population, of all Canadian provinces. Quebec and Nova Scotia had higher ratios of physicians to population. B.C. had Canada's highest ratio of general practitioners to population, and was slightly below the Canadian average in the ratio of specialists to population.

In contrast to British Columbia's relatively large number of physicians, the number of nurses per 100,000 population is lower in B.C. than in most other provinces. It is difficult to draw direct comparisons between provinces because each has its own unique health care system and way of utilizing nurses and other care providers. By early 1999, all provinces were beginning to feel the strain of an emerging nursing shortage and the need for a major recruitment effort.

Services Delivered

This section reports the rates at which various health services were utilized in 1999/2000, in different regions of the province and in comparison to previous years. Utilization rates indicate the proportion of the population who receive a given service. For services of proven effectiveness, such as immunization, cancer screening, blood pressure checks to detect hypertension and counseling on smoking cessation, these rates provide useful evidence on whether services are reaching those who need them. Low rates of utilization may indicate that some regions or groups are experiencing challenges in accessing services.

This information provides an estimate of the accessibility of services. With the exception of some diagnostic and preventative services such as immunization and pap smears, higher numbers of services delivered do not necessarily indicate success in improving the health of British Columbians.

Preventive Services

Immunization Rates, Two-Year-Old Children

Immunization programs for children are among the most cost-effective of all health services. In British Columbia, all infants and preschool children have access to immunizations to protect them from eight serious diseases, including diphtheria, tetanus, polio and measles.

In 1999, more than 80 per cent of B.C. children had been immunized by their second birthday. In some regions and communities, almost all two-year-olds were fully immunized, with rates approaching the national target of 97 per cent. However, there are other areas of the province where the level of coverage needs to improve.

For some areas of the province, immunization statistics for two-year-olds are not available, in part due to difficulties in gathering statistics from doctors' offices. A province-wide computerized immunization registry, currently being introduced within public health, will be able to provide more complete information in the future. Based on the information we have available, B.C. is doing as well as or better than other parts of Canada in meeting immunization goals and targets.

IMMUNIZATION PROGRAMS FOR CHILDREN ARE AMONG THE MOST COST-EFFECTIVE OF ALL HEALTH SERVICES. IN BRITISH COLUMBIA, ALL INFANTS AND PRESCHOOL CHILDREN HAVE ACCESS TO IMMUNIZATIONS TO PROTECT THEM FROM SEVERAL SERIOUS DISEASES.

Screening Services

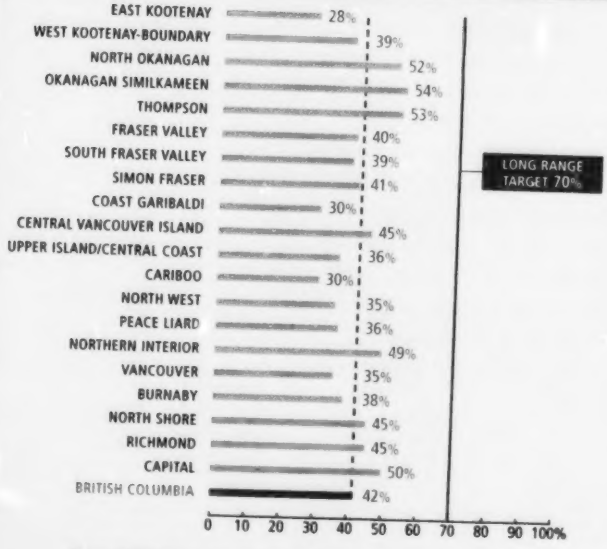
Screening Mammography

Screening mammography facilitates early detection and treatment of breast cancer. International studies have shown that screening mammography reduces death rates from breast cancer by 25 per cent or more if women between the ages of 50 and 69 are screened every two years.

The Screening Mammography Program of B.C. (SMPBC) began in 1988 and has expanded each year. SMPBC has extended the target age group to include women between 50 and 74, and data indicates that women 70 to 79 may also benefit from screening. The goal of SMPBC is to screen at least 70 per cent of women between ages 50 and 74. The program is gradually approaching its goal as more women attend screenings every year[1]. In 1996/1997, 36 per cent of B.C. women in this age group were screened by the SMPBC. By 1998, the number of women screened had increased to 43 per cent, but has declined to 42 per cent in 1999.

[1] *Some women receive screens performed at centres that are not affiliated with SMPBC, so are not included in these data. These women may add another ten percent to the percentage of women receiving screening mammography.*

SCREENING MAMMOGRAPHY PARTICIPATION FOR B.C. WOMEN AGED 50-74, 1998 AND 1999 INCLUSIVE

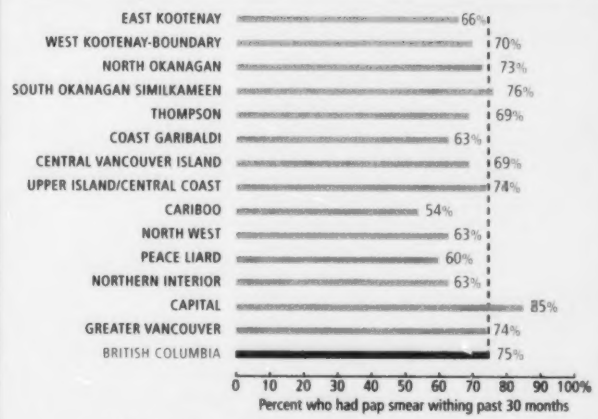


Source: 1998/1999 Annual Report, Screening Mammography Program of B.C.

Pap Smears

A pap smear is a sample of cells taken from the cervix of a woman's uterus. The sample is microscopically examined to identify pre-cancerous and cancerous changes. Since the 1960s, B.C. has been a pioneer in the implementation of a widespread pap smear program. A central laboratory at the B.C. Cancer Agency receives, reviews and reports all pap smears performed in the province. This coordinated pap smear program allows for a significant reduction in the incidence of cervical cancer through identification and treatment of pre-cancerous conditions. Over the past 30 years, the incidence of invasive cancer of the cervix in B.C. has been reduced by 85 per cent. International evidence-based research supports the screening of sexually active women between the ages of 20 and 69 at least every three years. In the 30 months between July 1997 to December 1999, the participation rate among B.C. women was 75 per cent. The literature shows that participation rates vary by level of income and education. The goal of the program is to ensure that all women in the target age group receive regular pap smears.

PAP SMEAR PARTICIPATION FOR B.C. WOMEN AGED 20-69 FOR THE PERIOD JULY 1997 TO DECEMBER 1999



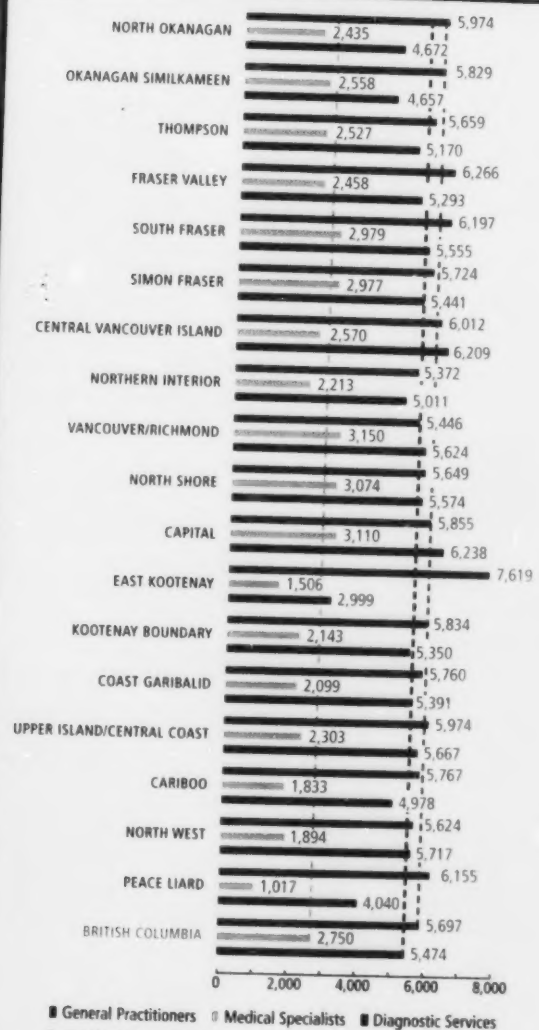
Source: BC Cancer Agency (Cervical Screening Program)

Notes:
1. 1999 population estimates: B.C. STATS. B.C. Ministry of Finance and Corporate Relations.
2. Population data acquired through Health Data Warehouse, B.C. Ministry of Health.
3. Women's addresses are not currently available to the Cervical Cancer Screening Program. Thus, the number of women from each region is estimated by using the address of the health care provider who has submitted the last pap smear during the reporting period.
4. Health Regions 6-8 and 16-19 have been combined into one mega region, Greater Vancouver, because women often cross over to other health regions to obtain pap smears (e.g. a woman living in Burnaby has her pap smears done by a Vancouver doctor).

Physician Services

Many British Columbians consider the use of medical and hospital services to be a key indicator of the success of our health system. However, more use of these services does not necessarily translate to better health and, in some cases, does not indicate that they are more accessible.

PHYSICIAN SERVICES PER 1,000 POPULATION, BY HEALTH AUTHORITY, B.C. 1999/2000*



Source: Medical Services Plan

*Includes fee for service data only.

A healthier population does not necessarily use medical and hospital services more than a less healthy population.

Utilization of medical services is relatively consistent across the province[2].

The total number of urgent and emergency surgeries performed in B.C. has remained relatively stable over the last five years, despite a growing and aging population. Some of this may be attributed to alternative forms of therapy replacing surgery, such as treating some conditions with drugs or new non-invasive techniques.

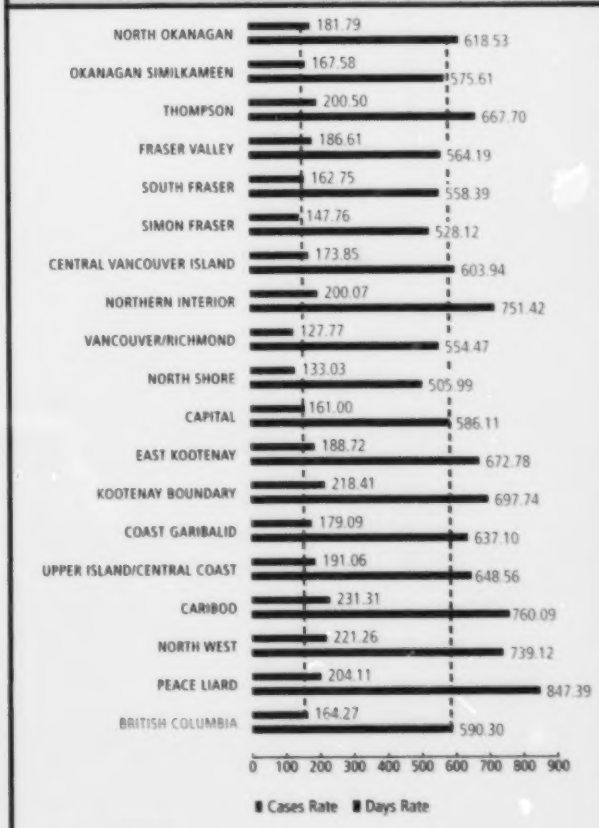
Between 1998/1999 and 1999/2000 the total number of surgical procedures increased by 6.5 per cent. In comparison, the total number of surgical procedures carried out in B.C. decreased by approximately 2.7 per cent during 1997/1998 and 1998/1999.

[2] *The utilization of services in the regions that border on Alberta – East Kootenays and Peace-Liard – are artificially low. This is because some residents in these areas use physicians located in Alberta, and that use is not recorded by the B.C. health system. In addition, the figures presented here do not include services paid for through the Medical Services Plan Alternative Payments program. As a result, figures are understated for some regions.*

Generally, rates of hospital use have decreased over the past five years, both in terms of cases and days per thousand population. However, the cases rate rose slightly over the past year by 3.3 per cent. The drop in days per thousand population continues a trend that has been underway for 30 years. Province-wide, the rate of acute, rehabilitation and surgical day care utilization has declined from 174.76 cases per thousand population in 1995/1996 to 159.00 in 1998/1999, rising slightly to 164.27 in 1999/2000.

Variation in cases and days between the regions is marked. Rural areas have higher rates of cases and days per thousand population. This may reflect poorer health status, more available hospital beds, and the difficulty of providing community care in some remote areas.

HOSPITAL DISCHARGE AGE-STANDARDIZED RATES IN B.C. 1999/2000
(INCLUDED DISCHARGES FROM ACUTE CARE, REHABILITATION CARE AND SURGICAL DAYCARE)


NORTH OKANAGAN 181.79 618.53
OKANAGAN SIMILKAMEEN 167.58 575.61
THOMPSON 200.50 667.70
FRASER VALLEY 186.61 564.19
SOUTH FRASER 162.75 558.39
SIMON FRASER 147.76 528.12
CENTRAL VANCOUVER ISLAND 173.85 603.94
NORTHERN INTERIOR 200.07 751.42
VANCOUVER/RICHMOND 127.77 554.47
NORTH SHORE 133.03 505.99
CAPITAL 161.00 586.11
EAST KOOTENAY 188.72 672.78
KOOTENAY BOUNDARY 218.41 697.74
COAST GARIBALID 179.09 637.10
UPPER ISLAND/CENTRAL COAST 191.06 648.56
CARIBOO 231.31 760.09
NORTH WEST 221.26 739.12
PEACE LIARD 204.11 847.39
BRITISH COLUMBIA 164.27 590.30
0 100 200 300 400 500 600 700 800 900
Cases Rate
Days Rate

Source: PURRFECT

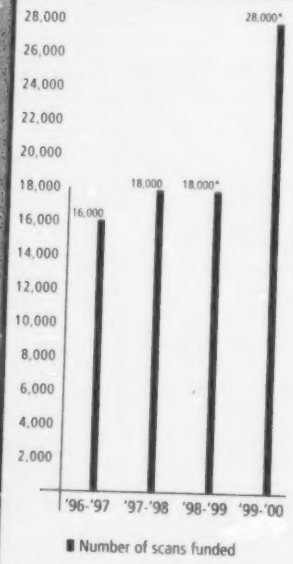
Note: Rates are per 1,000 population and are standardized using the indirect method and 19 age groups. Residents of B.C. treated out of province are included. Non-B.C. residents are excluded. Newborns are excluded.

Organ Transplants

The number of organ transplants that take place in British Columbia each year depends on the availability of donated organs. Improved safety measures in B.C. have reduced the number of premature deaths and limited the supply of donated organs. As a result, there has been a strong reliance on living organ donors for kidney transplants. Mandatory referral legislation is being developed to help improve the experience of donating organs as seen in other jurisdictions, notably Pennsylvania.

Following is a chart outlining the number of organ transplants in BC over the last twelve years. Greater detail is available through the British Columbia Transplant Society at www.transplant.bc.ca on the Internet.

MRI SCANS FUNDED IN B.C., 1996/1997 – 1999/2000



Source: Data maintained by Regional Programs.

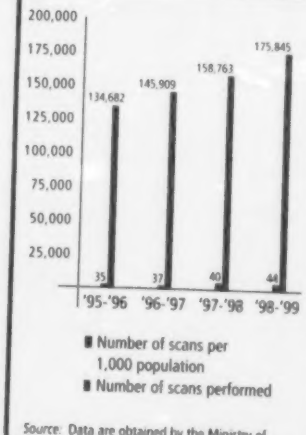
Note: The MRI data report only the number of scans funded by the Ministry of Health.

*In February 1999, funding for an additional 10,000 MRI scans was added, for a total of 28,000 MRI scans/year. Some MRI sites were able to increase the number of scans available in 1998/1999. Other sites required time to train technicians and did not begin delivering additional scans until 1999/2000.

CT and MRI Technology

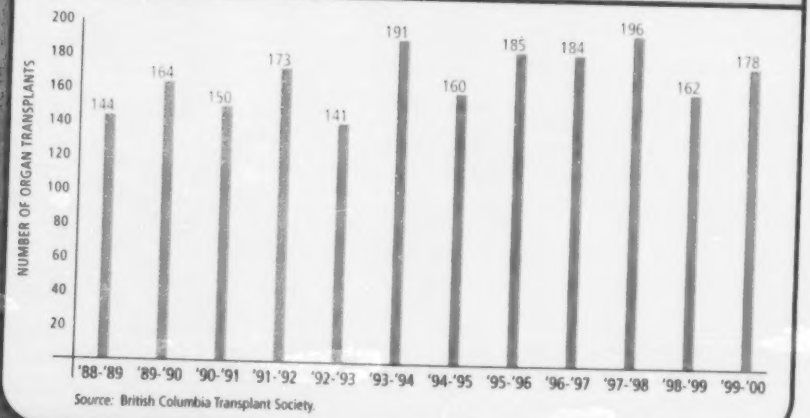
Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) are sophisticated radiological techniques. CT scanning uses x-ray technology whereas MRI scanning uses electromagnetic fields. Both involve multiple images being taken and assembled by a computer to produce three-dimensional images. These imaging techniques are useful for detection of many medical conditions. The technologies are very different, and each is useful for specific situations or conditions. The equipment is complex and expensive to purchase and operate. No data for 1999/2000 was available for CT scans at the time of preparing this report.

CT SCANS FUNDED IN B.C., 1995/1996 – 1999/2000



Source: Data are obtained by the Ministry of Health through annual survey of the sites.

ORGAN TRANSPLANTS IN B.C., 1988/1989 – 1999/2000



Source: British Columbia Transplant Society.

Pharmacare Beneficiaries and Expenditures, By Plan 1998/1999 and 1999/2000

Pharmacare is the provincial drug program that helps B.C. residents pay for eligible prescription drugs and designated medical supplies. Pharmacare benefits are provided by nine different plans for target groups: seniors (Plan A), residents of long-term care facilities (Plan B), persons receiving medical benefits from the Ministry of Social Development and Economic Security (Plan C), cystic fibrosis patients (Plan D), medically-dependent children (Plan F), persons receiving premium assistance who require psychiatric medication (Plan G), in-home patients requiring oxygen (Home Oxygen Program), patients receiving treatment for HIV/AIDS (B.C. Centre for Excellence) and all other residents of British Columbia (Plan E).

The chart illustrates Pharmacare fiscal-year expenditures and the number of beneficiaries under each plan. The expenditure amount includes payments for drug costs as well as compensation for pharmacists. The number of beneficiaries is the number of individuals who made a claim to Pharmacare that resulted in a Pharmacare payment on their behalf during the fiscal year.

PHARMACARE EXPENDITURES AND NUMBER OF BENEFICIARIES BY PLAN 1998/1999 – 1999/2000

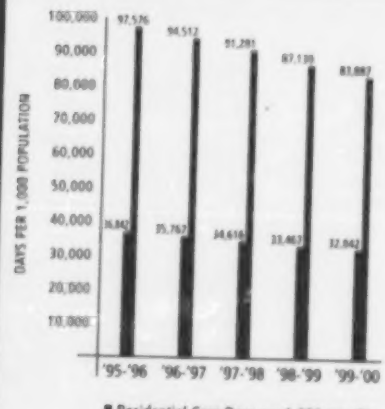
	1998/1999		1999/2000	
	BENEFICIARIES[2,3,4]	EXPENDITURE[1]	BENEFICIARIES[2,3,4]	EXPENDITURE[1]
PLAN A	419,792	$248,443,480	432,295	$278,275,498
PLAN B	24,869	$27,671,121	24,928	$29,088,731
PLAN C	225,127	$104,051,470	218,954	$119,955,953
PLAN D	255	$644,212	267	$674,225
PLAN E	161,080	$67,401,595	180,049	$79,929,818
PLAN F	1,783	$2,565,690	1,874	$2,663,691
PLAN G	8,312	$5,594,394	10,381	$7,265,341
TOTAL PLANS A TO G	**825,344**	**$456,371,962**	**851,568**	**$517,853,257**
HOME OXYGEN PROGRAM[5]	7,190	$14,383,983	7,579	$13,733,463
BC CENTRE FOR EXCELLENCE	3,262	$26,569,271	3,432	$30,240,190
TOTAL FOR ALL PLANS		**$497,325,216**		**$561,826,910**

Source Notes:
1. The 1999/2000 figures for expenditures are taken from the Ministry of Health Financial Management Report dated March 31, 2000; the 1998/1999 figures for expenditure are taken from the same report date May 5, 1999.
2. The beneficiary counts for plans A through G are taken from the Pharmacare Fiscal Year-To-Date, by Plan Report. The beneficiary counts for the Home Oxygen Program are taken from the Home Oxygen Invoice Totals Report. The beneficiary count for the B.C. Centre of Excellence are taken from the BCCFE Annual Report.
3. The number of beneficiaries includes only those individuals with a Pharmacare paid claim in the fiscal year reported.
4. The number of beneficiaries are not additive across plans as an individual may have received a benefit under more than one plan during the fiscal year. The total number of beneficiaries reported here reflects the distinct number of beneficiaries with a Pharmacare paid claim in the fiscal year across all plans.
5. The Home Oxygen Program expenditure figure contains the amount for the Capital Health Region; however, the number of beneficiaries in the Capital Health Region is not included in the Home Oxygen Program beneficiary count as this figure is not available through the current reporting system.

Residential and Home Care

Over the past five years, British Columbia's population aged 75 and older has grown at more than twice the rate of growth in the general population. The number of people aged 75 and older has increased by 17 per cent, and the number of people aged 85 and older has increased by 25 per cent.

RESIDENTIAL CARE, DAYS PER 1,000 POPULATION AGE 75+ AND 85+, B.C. 1995/1996 – 1999/2000



Source: Continuing Care Data Warehouse, September 2000, B.C. Ministry of Health

Although residential care utilization has remained nearly constant over the past five years, increased population has resulted in fewer days per capita. As a result, there has been a decrease in residential days per 1,000 population aged 75-plus and 85-plus by 11 per cent and 14 per cent respectively. During this time period, more clients with lighter care needs (Personal Care and Intermediate Care - Level 1) were being maintained at home instead of being admitted to a residential care facility, resulting in seven per cent fewer lighter care clients occupying residential care beds. The number of clients assessed as having the heaviest care needs (Intermediate Care – Level 3 and Extended Care) increased by seven per cent over the past five years.

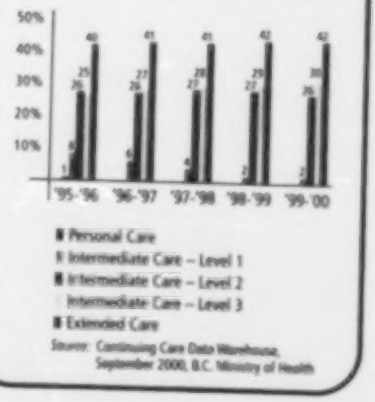
Direct care offers health care services to people in their homes. Services include Home Nursing care and rehabilitation therapy, such as physiotherapy and occupational therapy.

Direct Care Admissions have increased overall by 7,724 or 12 per cent over the past five years. Admissions per 1,000 population under age 75 have remained stable. In the population aged 75 and older, admissions per 1,000 population have increased by 3 per cent.

Although home support paid hours have increased slightly over the past five years, the increased population of older British Columbians has resulted in fewer paid hours per capita. There has been a decrease in paid hours per 1,000 population aged 75-plus and 85-plus by 8 per cent and 2 per cent respectively.

In addition, there has been a shift in paid hours of services for clients with lighter care to clients with higher care needs. Over the past five years, paid hours of home support for lighter care clients (Personal Care and Intermediate Care – Level 1) have decreased by 16 per cent and the number of paid hours for heavier care clients (Intermediate Care – Level 3 and Extended Care) has increased by 10 per cent.

RESIDENTIAL CARE DAYS BY LEVEL OF CARE, B.C. 1995/1996 – 1999/2000

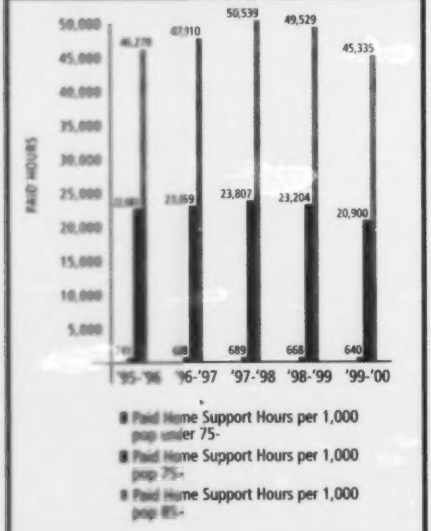


Source: Continuing Care Data Warehouse, September 2000, B.C. Ministry of Health

WAITING TIMES

Waiting times for surgery, treatment and diagnostic procedures have always been a major focus of public attention. It is essential that we keep waiting times short enough to protect health and minimize pain, worry and inconvenience. However, as with the other performance measures in this section, it is important to avoid making assumptions about waiting times. It is often forgotten that emergency cases do not go on waiting lists at all. While shorter waiting times are preferable, waiting times for elective services do not necessarily lead to poorer health.

HOME SUPPORT SERVICES UTILIZATION PER 1,000 AGE GROUP POPULATION UNDER 75, 75+ AND 85+, BC 1995/1996 – 1999/2000



Source: Continuing Care Data Warehouse, September 2000, B.C. Ministry of Health

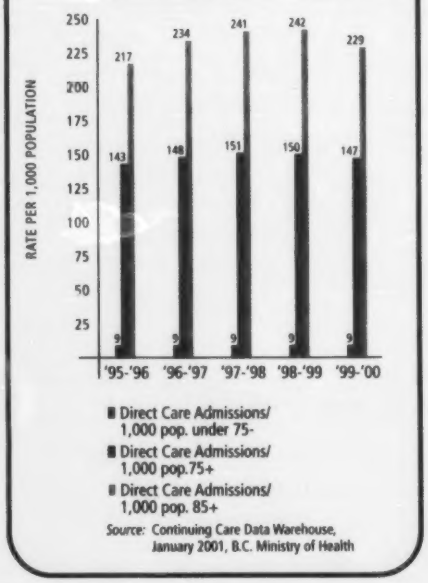
Note: These figures do not include Community Support for Independent Living clients (CSIL) – this combined with a change in policy resulting in fewer homemaker hours to personal care clients is likely causing the decrease.

Some increases in waiting times can take place as a result of short-term factors and can be addressed through targeted actions. However, to reduce waiting times over the long-term, the system's capacity must be increased, which is a more complex and long-term undertaking.
In making decisions about waiting times, it is important to be clear on the actual health effects of waiting times and to compare the benefits of reducing waiting times with investing the same resource in other areas of the health care system.

Surgical Procedures and Treatments

An elective case is one where the patient is able to wait without damage to his or her health. An emergency case is one in which the patient's health depends on immediate surgery. The waiting times presented in this report include only elective cases, as emergency cases proceed without patients being placed on a waiting list.

DIRECT CARE ADMISSIONS PER 1,000 AGE GROUP POPULATION BY AGES UNDER 75, 75+ AND 85+, 1995/1996 – 1999/2000



Source: Continuing Care Data Warehouse, January 2001, B.C. Ministry of Health

IT IS ESSENTIAL THAT WE KEEP WAITING TIMES SHORT ENOUGH TO PROTECT HEALTH AND MINIMIZE PAIN, WORRY AND INCONVENIENCE.

WAITING TIMES FOR ELECTIVE SURGICAL PROCEDURES B.C., 1996/1997 – 1999/2000

	MEDIAN WAIT MAR '97	SURGERIES APR '96-MAR '97	MEDIAN WAIT MAR '98	SURGERIES APR '97-MAR '98	MEDIAN WAIT MAR '99	SURGERIES APR '98-MAR '99	MEDIAN WAIT MAR '00	SURGERIES APR '99-MAR '00
CARDIAC SURGERY	16 weeks	1,465	16 weeks	1,634	11 weeks	1,586	9 weeks	1,374
DENTAL SURGERY	4.5 weeks	5,424	4.4 weeks	5,402	5.1 weeks	5,064	7.3 weeks	5,830
EAR, NOSE & THROAT	4.4 weeks	14,828	4.1 weeks	14,997	5 weeks	13,168	6.1 weeks	14,127
GENERAL SURGERY	3 weeks	33,857	3 weeks	36,100	3.6 weeks	32,646	3.4 weeks	36,990
GYNAECOLOGY	2.4 weeks	29,686	2.4 weeks	30,188	3 weeks	27,456	3.3 weeks	28,205
NEUROSURGERY	2.4 weeks	3,985	2.7 weeks	4,009	3.1 weeks	3,478	3.6 weeks	4,247
OPHTHALMOLOGY	6.1 weeks	26,162	6.1 weeks	26,779	8.1 weeks	22,193	8.9 weeks	26,087
ORTHOPEDICS	5.9 weeks	25,892	5.4 weeks	27,329	7.3 weeks	25,423	6.9 weeks	27,049
PLASTIC SURGERY	5.4 weeks	8,258	6.5 weeks	8,344	7.6 weeks	7,776	5.4 weeks	8,527
UROLOGY	3.1 weeks	24,198	2.9 weeks	24,382	3.1 weeks	22,143	4.1 weeks	23,199
VASCULAR SURGERY	1.7 weeks	3,170	1.7 weeks	3,366	1.9 weeks	2,977	1.4 weeks	3,958

Source: Surgical Waitlist Registry.

Note: These figures do not include certain procedures carried out in small facilities or certain minor elective procedures.

Median wait is based on procedures performed over the previous 6 months. Data is taken from the Surgical Wait List Registry. The data includes booked surgeries for hospitals participating in the Registry. It does not include emergency surgeries since these are not booked.

A total of 402,230 surgical procedures were performed in B.C. during 1999/2000. Of these, 380,108 were elective and the remaining 22,122 were emergency.

Public attention often focuses on the number of cases waiting for a particular procedure. However, for a person who is waiting, it is usually more important to know the length of the wait rather than the number of people on the list. Therefore, waiting times are used in this and other reporting by the Ministry of Health.

3 Median wait time is based on procedures performed over the previous six months. Data is taken from the surgical waitlist registry. The data includes booked surgeries for hospitals participating in the registry. It does not include emergency surgeries since these are not booked.

As the charts indicate, the median wait time[3] for surgery in B.C. remained relatively steady from the mid-1990s to 1998, even for high demand procedures such as hip and knee replacement surgery and cataract surgery. During this period, the total number of surgeries performed increased.

During the 1998/1999 fiscal year, the number of surgeries dipped and median wait times for elective procedures increased particularly for hip and knee replacement surgeries, in spite of increased funding for health care.
In 1999/2000, the number of surgeries performed increased. For some procedures these increases were quite dramatic.

NON-EMERGENCY CARDIAC SURGERY WAIT TIMES B.C., 1995/1996 – 1999/2000

	MARCH 1996	SEPT 1996	MARCH 1997	SEPT 1997	MARCH 1998	SEPT 1998	MARCH 1999	DEC 1999
Median wait (in weeks)	10	12	16	14	16	12	11	10

Source: BC Cardiac Registry.

CATARACT SURGERY WAIT TIMES B.C., 1996/1997 – 1999/2000

	JUNE 1996	DECEMBER 1996	JUNE 1997	DECEMBER 1997	JUNE 1998	DECEMBER 1998	JUNE 1999	DECEMBER 1999
Patients waiting	6,679	6,147	6,754	6,925	6,938	7,175	6,717	9,113
Cases completed (previous 6 months)	10,423	10,271	10,969	10,053	10,658	8,691	10,398	10,257
Median wait	7.7	8.1	7.3	8.9	6.6	9.9	10	10

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry.

HIP REPLACEMENT WAIT TIMES B.C., 1996/1997 – 1999/2000

	JUNE 1996	DECEMBER 1996	JUNE 1997	DECEMBER 1997	JUNE1998	DECEMBER 1998	JUNE1999	DECEMBER 1999
Patients waiting	696	781	851	912	1,060	1,305	1,385	1,395
Cases completed (previous 6 months)	1,111	998	1,191	998	1,158	813	1,163	1,050
Median wait	8.0	9.0	9.4	9.9	10.6	12.4	16.4	19.7

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry.

KNEE REPLACEMENT WAIT TIMES B.C., 1996/1997 – 1999/2000

	JUNE 1996	DECEMBER 1996	JUNE 1997	DECEMBER 1997	JUNE 1998	DECEMBER 1998	JUNE 1999	DECEMBER 1999
Patients waiting	802	897	1,062	1,121	1,371	1,623	1,780	1,815
Cases completed (previous 6 months)	929	885	1,079	924	1,072	784	1,110	1,115
Median wait	11.6	12.0	11.3	12.9	13.0	16.7	20.1	22.9

(in weeks, over previous 6 months)

Source: Surgical Waitlist Registry.

CORNEAL TRANSPLANTS WAIT TIMES, B.C. 1996/1997 – 1999/2000

	MEDIAN WAIT MAR '97	SURGERIES APR '96-MAR '97	MEDIAN WAIT MAR '98	SURGERIES APR '97-MAR '98	MEDIAN WAIT MAR '99	SURGERIES APR '98-MAR '99	MEDIAN WAIT MAR '00	SURGERIES APR '99-MAR '00
Corneal Surgery	9 months	537	6 months	487	5 months	503	5 months	422

Source: Eye Bank of BC.

Information on Selected Procedures

The median wait time for cataract surgery was stable until mid-1998, after which the median wait time increased.

The median wait time for hip and knee replacement surgery continues to increase, which is an indication of the demand for these procedures. The number of surgeries performed in 1999/2000 increased significantly from the previous year, yet the median wait continued to climb.

Waiting times for corneal transplants depend to a great extent on availability of corneal tissue. Despite a shortage of tissue supply, the Corneal Transplant Program has been able to reduce the waiting list and waiting time substantially over the past three years.

Many factors can account for the wait time increase, including increases in emergency services and availability of staff or operating room time. Health authorities and the Ministry of Health routinely monitor wait times and, when necessary, intervene by providing funding to address wait time peaks, rescheduling operating room arrangements or taking other administrative measures to increase surgical throughput.

IN 1998, THE MINISTRY OF HEALTH ADDED AN EXTRA $8.5 MILLION TO PERFORM 450 MORE CARDIAC SURGERIES, MORE ANGIOPLASTY PROCEDURES AND OTHER IMPROVEMENTS TO CARDIAC CARE. AS A RESULT, THE DECEMBER 1999 MEDIAN WAIT TIME WAS THE SHORTEST IT HAD BEEN IN MORE THAN THREE YEARS.

Half of all heart surgery patients in B.C. receive their surgery on an emergency basis. For the other half of patients, surgically classified as non-urgent cases, B.C. has a well-developed cardiac registry that monitors wait lists, wait times and treatments for cardiac disease.

The number of heart operations performed each year has grown proportionally faster than B.C.'s population. In 1998, the Ministry of Health added an extra $8.5 million to perform 450 more cardiac surgeries, more angioplasty procedures and other improvements to cardiac care. As a result, the December 1999 median wait time was the shortest it had been in more than three years.

Waiting times for cancer radiation therapy increased from 1.1 weeks to 2 weeks between March 1996 and March 1999. The ministry is improving access to radiotherapy services by constructing a new and expanded cancer clinic in Victoria, installing a fifth radiotherapy machine in Surrey and increasing services in Kelowna.

Another element of cancer waiting times is the time a patient must wait to see an oncologist.

Emergency

British Columbia Ambulance Service

Research has shown that patients with severe injury or illness such as major trauma or cardiac arrest benefit from reduced ambulance response times. The B.C. Ambulance Service (BCAS) adopted a method of response time reporting that shows the percentage of responses that meet or exceed the standard for each category of ambulance calls. The call categories are:

Alpha Call: those illnesses or injuries in which patient outcome will not be affected. The response time standard is 15 minutes or less.

Bravo Call: those medical emergencies where time may affect patient outcome. The response time standard is ten minutes or less.

Charlie Call: potentially life-threatening emergencies where time may affect patient outcome. The response time standard is ten minutes or less.

Delta Call: the most serious life-threatening emergencies where response time is of the essence. The response time standard is eight minutes or less.

The goal adopted by the BCAS is to meet the Delta response time standard of eight minutes or less, 90 per cent of the time in metropolitan/urban areas.

CANCER RADIATION THERAPY WAIT TIMES B.C., 1996/1997 – 1999/2000

	MEDIAN WAIT MAR '97*	COURSES OF TREATMENT 1997	MEDIAN WAIT MAR '98	COURSES OF TREATMENT 1998	MEDIAN WAIT MAR '99	COURSES OF TREATMENT 1999	MEDIAN WAIT MAR '00	COURSES OF TREATMENT 2000
Radiation Therapy	1.1 weeks	8,334	1.4 weeks	8,670	1.6 weeks	9,616	2 weeks	9,782

Note: *Median Wait is based on courses of treatment performed over the previous 6 months.
Source: BC Cancer Agency

In 1999/2000, the average response time to the most urgent ambulance or Delta calls in the City of Vancouver was 8.1 minutes. The average response time to Delta calls in the Greater Vancouver Regional District was 9.2 minutes.

The BCAS continued to work on operational strategies aimed at reducing response times as the provincial total call volume increased 4.2 per cent over the year. During this period, our ambulances continued to experience periodic delays in the unloading of patients at the emergency wards of hospitals in the Lower Mainland and occasionally in other areas. In December 1999, the BCAS implemented a temporary strategy of locating paramedic staff at the busiest hospital emergency wards to assist ambulance crews to return to active emergency coverage more quickly. This system proved effective in maintaining overall response times, especially during periods of peak demand.

The BCAS also implemented a new Medical Priority Dispatch System in the three Regional Dispatch Centres. This new system has given dispatchers an improved and more accurate method of assessing medical emergency calls and determining the correct level of response. The Quality of Assurance process documented the high rate of compliance to the system by ambulance dispatchers. This has resulted in an improved and more consistent call assessment process.

QUALITY

British Columbians expect high quality services when they need them. The quality of health services depends on the skills of the providers, the facilities and equipment used, and on the organisation and administration of the services.

The meaning of the term 'quality' and how to measure it are matters of opinion. Quality means different things to different people. Some would measure quality by the perceptions of people who use the system. Others would use statistical measures of efficiency. And others would focus on the assessment of health outcomes.

Many current indicators and measurements of quality have been used. The Canadian Institute of Health Information (CIHI) has determined that no single measure of quality exists and that the best approach is to use a variety of quality indicators.

The following indicators are relatively simple and are presented as examples of how we might measure the quality of our health system. The ministry is working to develop indicators across service lines to provide a comprehensive, meaningful picture of service quality in the future.

Breast-Conserving Surgery

Breast cancer is the most common cause of death due to cancer in women. The treatment of breast cancer depends on how far it has spread. It is now considered preferable to treat localized cancer with breast-conserving surgery rather than complete mastectomy. Studies have shown that women who have breast-conserving surgery followed by radiation therapy have the same survival rates as those undergoing complete mastectomy. Since breast-conserving surgery is less traumatic, physically and psychologically, it is a desirable practice. Increased use of breast-conserving surgery is considered an indicator of improved health care quality.

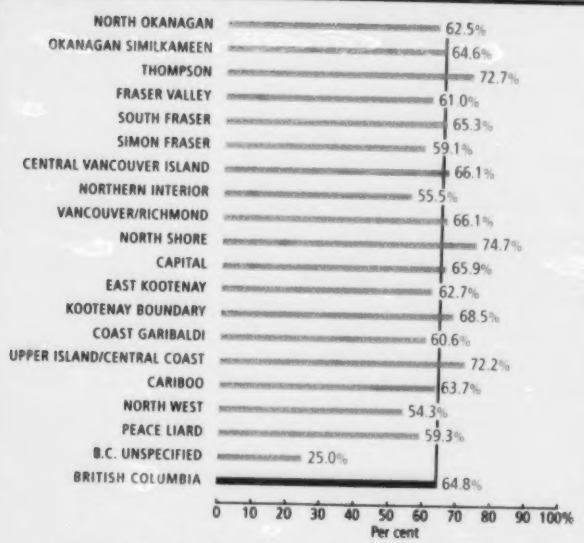
In Canada, the rate of breast-conserving surgery is reported by Canadian Institute for Health Information.

The level of breast-conserving surgery as a proportion of all cases of breast cancer has changed little over the past five years. The rate of breast-conserving surgery has risen from 62 to 65 per cent[4].

Only a small part of the variation between B.C. regions is due to differences in the incidence of breast cancer. There is little reason to believe that the severity of cases is very different among geographic regions. Variation in rates among geographic areas might be due to small numbers of cases, while variation in the larger regions is likely due to differences in clinical practice.

4 *Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.*

BREAST CONSERVING SURGERY AS PER CENT OF ALL FEMALE BREAST CANCER SURGERY, 1993/1994 – 1998/1999 (BY HEALTH AUTHORITY)



Source: Morbidity database, Information Support Branch, B.C. Ministry of Health

Note: 1. Report was produced using acute/day care surgery.

2. Restricted to females with diagnostic code 174. Malignant Neoplasm of the Female Breast.

3. Breast conserving surgery includes all procedure codes 97.21, 97.22, 97.11, 97.27 or 97.28 and no code of 97.12, 97.14, 97.16 or 97.18.

4. All breast cancer surgeries include all procedure codes 97.21, 97.22, 97.11, 97.27, 97.28, 97.15, 97.14.

Immunization for Seniors

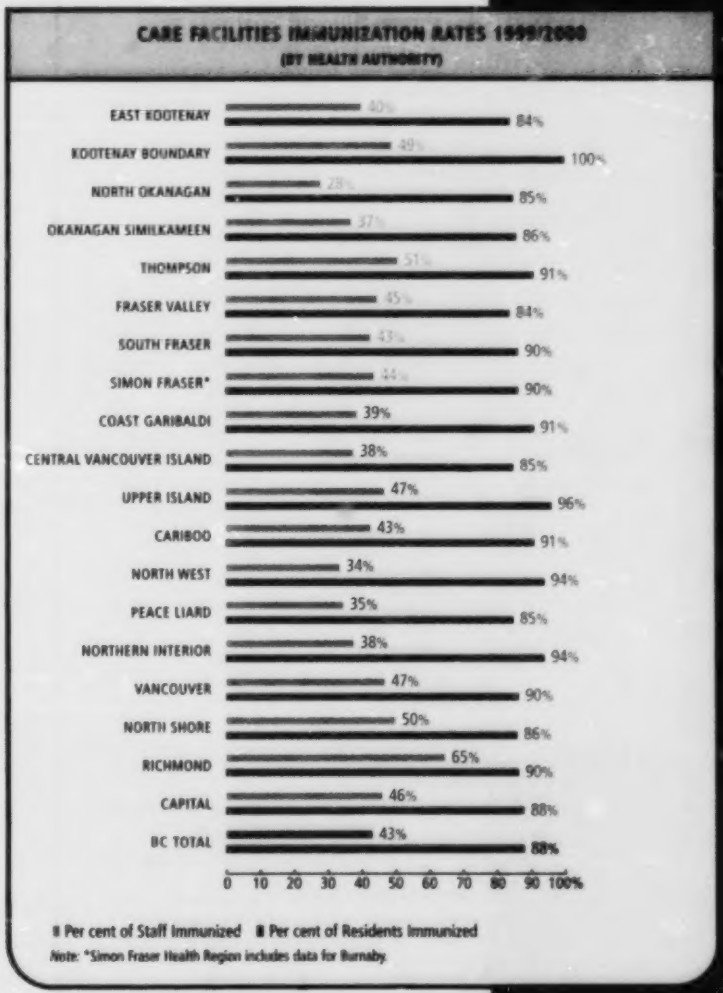
Influenza is a major cause of illness, hospitalization and death among older persons and among people with certain medical conditions. Annual influenza immunization prevents influenza-like illness and lessens the severity of disease.

For pneumococcal immunization, a one-time dose provides life-long protection for most people. Publicly funded pneumococcal immunization for all people age 65 and older began in April 1998. An estimated 64 per cent of British Columbians age 65 and older had an influenza shot during the 1999/2000 flu season – far below the proposed target of 90 per cent.

Another important population group is residents of long-term care facilities. This group is particularly vulnerable to influenza because of their age, medical condition and group living situation. For facility residents, the vaccination rate is commendable: 88 per cent received influenza vaccine in 1999/2000. In several regions, rates have surpassed the national goal of 90 per cent, while many other regions are approaching this goal.

To protect health care workers and the people they care for, it is vitally important that health staff be immunized. In 1999/2000, the immunization rate for staff of care facilities was only 43 per cent, up from 32 per cent the previous year, but still far below the 90 per cent target.

Immunization coverage could be improved for all risk groups, especially people age 65 and older, people with chronic diseases in all age groups, and health care workers.


CARE FACILITIES IMMUNIZATION RATES 1999/2000
(BY HEALTH AUTHORITY)
EAST KOOTENAY 40% 84%
KOOTENAY BOUNDARY 49% 100%
NORTH OKANAGAN 28% 85%
OKANAGAN SIMILKAMEEN 37% 86%
THOMPSON 51% 91%
FRASER VALLEY 45% 84%
SOUTH FRASER 43% 90%
SIMON FRASER* 44% 90%
COAST GARIBALDI 39% 91%
CENTRAL VANCOUVER ISLAND 38% 85%
UPPER ISLAND 47% 96%
CARIBOO 43% 91%
NORTH WEST 34% 94%
PEACE LIARD 35% 85%
NORTHERN INTERIOR 38% 94%
VANCOUVER 47% 90%
NORTH SHORE 50% 86%
RICHMOND 65% 90%
CAPITAL 46% 88%
BC TOTAL 43% 88%
0 10 20 30 40 50 60 70 80 90 100%
Per cent of Staff Immunized
Per cent of Residents Immunized
Note: *Simon Fraser Health Region includes data for Burnaby

Mental Health Readmissions to Hospitals

Severe mental health disorders such as bipolar disorders and schizophrenia are the most common reasons for admission to hospital with a diagnosis related to mental health.

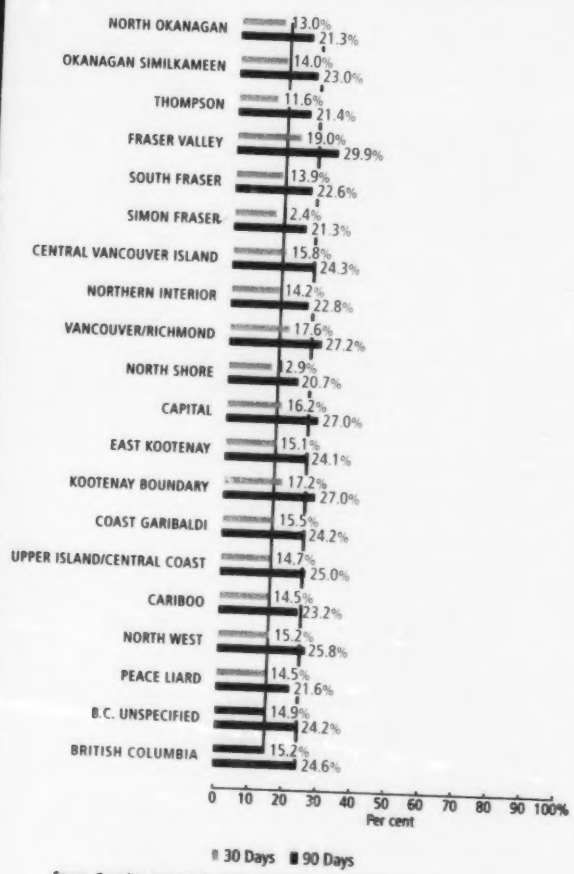
While admission may be necessary for acute treatment, most patients can be well-maintained in the community with regular follow-up and support services. Lower rates of re-admission to hospital soon after discharge are considered to be an indicator of improving health care quality.

The chart shows the readmission percentages for patients discharged from hospital with a principal diagnosis of severe mental illness.

Of the 20,443 discharges province-wide in 1999/2000, 15.2 per cent were readmitted within 30 days, another 5.7 per cent within 60 days and an additional 3.7 per cent within 90 days. This is a reduction from the previous year when 16.9 per cent were readmitted within 30 days. There is considerable variation among regions. In six regions, 25 per cent or greater of discharged mental health acute care patients were readmitted within 90 days. In all regions, the majority of readmissions occur within 30 days following discharge from hospital. Regional breakdowns do not support a suggestion that there might be a trade-off relationship between availability of community mental health services and hospital readmission[5].

5 *Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.*

MENTAL HEALTH ACUTE READMISSIONS, 1999/2000


NORTH OKANAGAN 13.0% 21.3%
OKANAGAN SIMILKAMEEN 14.0% 23.0%
THOMPSON 11.6% 21.4%
FRASER VALLEY 19.0% 29.9%
SOUTH FRASER 13.9% 22.6%
SIMON FRASER 12.4% 21.3%
CENTRAL VANCOUVER ISLAND 15.8% 24.3%
NORTHERN INTERIOR 14.2% 22.8%
VANCOUVER/RICHMOND 17.6% 27.2%
NORTH SHORE 12.9% 20.7%
CAPITAL 16.2% 27.0%
EAST KOOTENAY 15.1% 24.1%
KOOTENAY BOUNDARY 17.2% 27.0%
COAST GARIBALDI 15.5% 24.2%
UPPER ISLAND/CENTRAL COAST 14.7% 25.0%
CARIBOO 14.5% 23.2%
NORTH WEST 15.2% 25.8%
PEACE LIARD 14.5% 21.6%
B.C. UNSPECIFIED 14.9% 24.2%
BRITISH COLUMBIA 15.2% 24.6%
0 10 20 30 40 50 60 70 80 90 100%
Per cent
30 Days
90 Days

Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.

Note: Includes hospital separations for all levels of care with the exception of day surgery.

Hospital separations for out-of-province residents are excluded.

Hospital separations are based on a primary diagnosis being an ICD9 code between 290 and 314, V61 or V62.

Hospital separations with a PHN of 0 are excluded from this data.

Hospital separations and admissions for the same client the occurred on the same day and excluded to be consistent with re-admission data which uses the same client.

B.C. residents that are treated in other provinces are excluded.

Grouping by Health Authority is based on RHB/CHSS of the client at the time of hospital discharge.

The readmission data may be incomplete as not all hospitals have reported the first 90 days of 2000/2001.

Hip Replacement Surgery

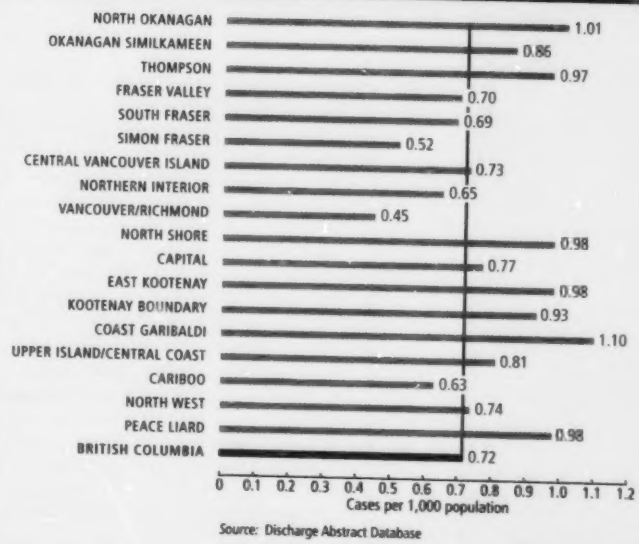
Over the past seven years, the rate of hip replacement in B.C. has remained relatively stable at 0.6 to 0.7 cases per 1,000 population. The number of cases was fairly constant from 1995/1996 to 1997/1998 at approximately 2,650. In 1998/1999, the number of cases dropped by over 100. In 1999/2000, the number of cases rose to 2,880. Lengths of stay per case have dropped steadily over the six years, from 10.6 days in 1993/1994 to 6.1 days in 1998/1999. In 1999/2000 the average length of stay per case rose to 6.4 days.

As the table indicates, regions varied in 1999/2000: 0.4 cases per 1000 population in Vancouver/ Richmond region, 0.5 cases per 1,000 population in Simon Fraser, 1.0 cases per 1000 in the North Okanagan, and 1.1 per 1,000 population in the Coast Garibaldi region. This degree of variation has persisted through the years. Similar levels of variation are found in Ontario but are not statistically significant[6].

[6] *van Walraven C, Paterson JM, Kapral M, Chan B, Bell M, Hawker GA, et al. Appropriateness of primary total hip and knee replacements in regions of Ontario with high low utilization rates. Can Med Assoc J. 1996; 155(6):697-706.*

There is no significant difference between rural and urban areas in the rates of surgery, although residents of the Lower Mainland generally have a rate at or below the provincial average, whereas those living elsewhere have rates at or above the provincial rate.

HIP REPLACEMENT SURGERY RATE, B.C., 1999/2000 (CASES PER 1,000 POPULATION)



Source: Discharge Abstract Database

Note: Includes out of province cases. (i.e. B.C. residents treated out of province)

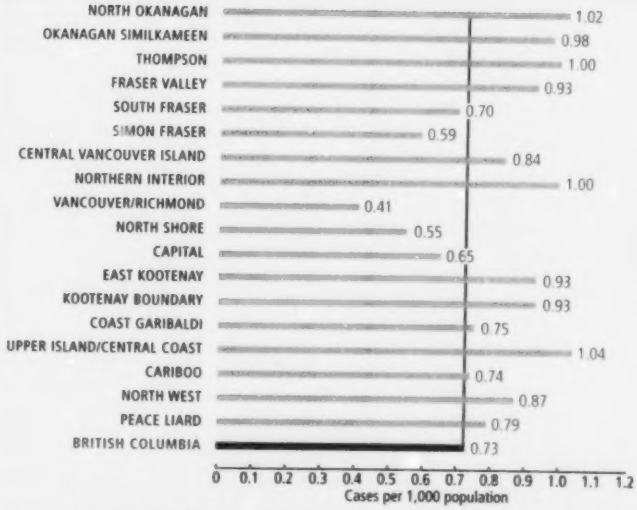
Knee Joint Replacement Surgery

The rate of knee replacements remained steady between 1995/1996 and 1998/1999 at 0.6. In 1999/2000 the rate rose to 0.7. The number of cases has increased from 2,291 in 1995/1996 to 2,918 in 1999/2000, an increase of 27 per cent. Lengths of hospital stay have been dropping steadily for six years, from 7 days in 1993/1994 to 5 days in 1998/1999. There was a slight increase in 1999/2000 to 5.7 days.

As with hip replacement, regions varied in their utilization rates in 1999/2000: 0.41 cases per 1,000 population in Vancouver/ Richmond; 1.0 cases per 1,000 in the Northern Interior; 1.02 in North Okanagan; and 1.04 in Upper Island/Central Coast. Major population centres in the Lower Mainland and Victoria had rates below the provincial average, while rural regions had rates above the provincial average.[7]

7 Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.

KNEE JOINT REPLACEMENT SURGERY RATE, B.C. 1999/2000 (CASES PER 1,000 POPULATION)



Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.

Note: Includes out of province cases.

Cataract Surgery

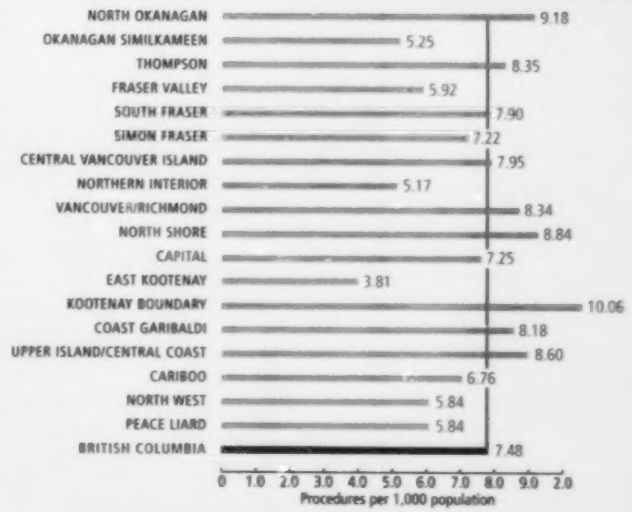
Cataract surgery is the removal of a clouded lens from one or both eyes and the insertion of an artificial lens. This improves eyesight considerably. Clouding of the lens is a condition that becomes more common as people grow older. There is no known way to prevent most cases of this condition. As techniques have improved over the years, the procedure has changed from being performed as an inpatient procedure to being performed on an outpatient basis.

The rate of cases has risen from 5.46 per 1,000 population in 1993/1994 to 7.48 per 1,000 in 1999/2000. In 1998/1999 the rate was 6.6 per 1,000. The rate will likely continue to rise over the next number of years as the population ages and demand increases. Variation among regions ranges from 3.81 per 1,000 in East Kootenay to 10.06 cases per 1,000 in the Kootenay Boundary region[8].

Lower rates in the East Kootenay region can likely be explained by the fact that day care surgery carried out on B.C. residents in Alberta facilities is not included in these figures.

[8] *Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.*

CATARACT SURGERY RATE (PROCEDURES PER 1,000 POPULATION) 1999/2000



Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.

Note: Includes out of province cases.

Admission to Hospital for MNRH Conditions

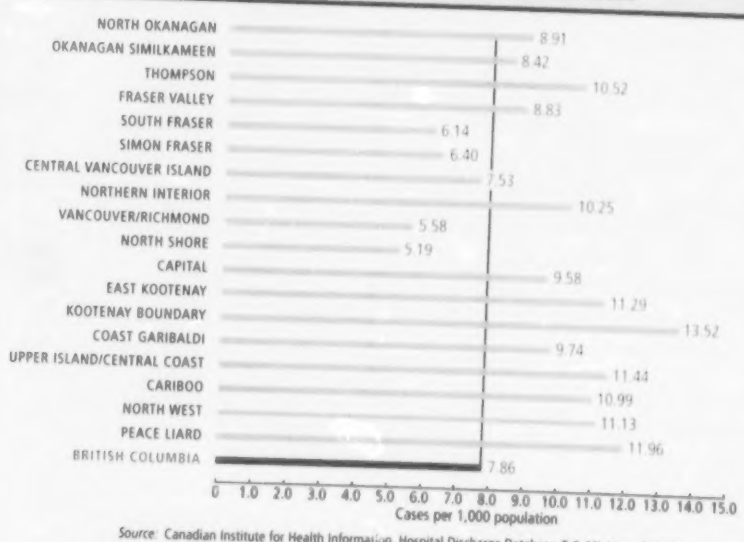
By analysing all the cases discharged from hospitals throughout Canada, the Canadian Institute for Health Information (CIHI) regularly identifies cases that may not require admission to hospital as an inpatient. A May Not Require Hospitalisation (MNRH) is a case where a patient is admitted to hospital even though the patient could have been treated on an ambulatory basis. A lower rate of admission to hospital for MNRH conditions is considered to be an indicator of improving health care efficiency. The data indicates a consistently dropping rate of MNRH cases per 1,000 population over the past five years.

This would be consistent with continued efforts to avoid unnecessary hospitalisation. In addition to dropping in absolute terms, MNRH cases have dropped as a percentage of all inpatient cases – from 10.1 per cent in 1995/1996 to 8.5 per cent in 1998/1999 and to 8.07 per cent in 1999/2000.

Variation among regions is relatively high, with a rate of 5.19 cases per 1,000 population in the North Shore region and 13.52 cases per 1,000 in the Kootenay Boundary Region in 1999/2000[9].

9 Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, B.C. Ministry of Health.

RATE OF HOSPITAL ADMISSION PER 1,000 FOR 'MAY NOT REQUIRE HOSPITALIZATION', B.C. 1999/2000



Source: Canadian Institute for Health Information, Hospital Discharge Database, B.C. Ministry of Health.

Note: Includes out of province cases.

FINANCIAL SUSTAINABILITY

The overall level of health care spending has long been viewed as a sign of the relative health of the system. However, health does not necessarily improve because more is spent on health care. The fiscal challenges facing all governments make it essential that we make more effective use of health resources rather than simply equating higher spending with success. By reducing unnecessary or inappropriate use of health services, more resources are available for things that do make a positive difference to the health of British Columbians.

This section includes examples of both approaches to measuring success in terms of health spending: simple measures of dollars spent and an example from the Medical Services Commission on measuring the effectiveness of spending.

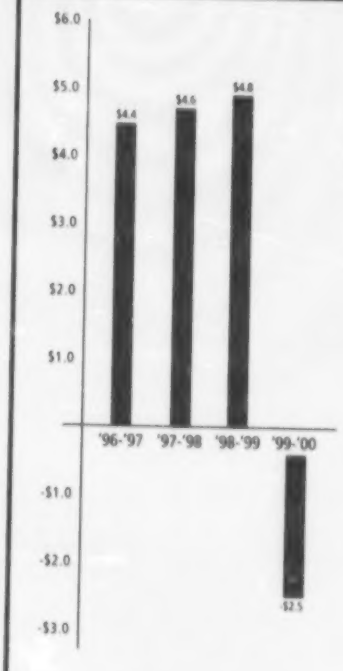
The Effect of Guidelines and Protocols

The Medical Services Commission (MSC) has adopted clinical practice guidelines and protocols that improve care and reduce unnecessary or inappropriate use of doctors' services, thereby making more resources available for services that make a real positive difference to people's health.

This guideline and protocol initiative is an example of the ministry working with physicians, surgeons and other medical practitioners to review and provide to practitioners the best available information on appropriate care for common situations. The effectiveness of this approach is shown in the graph below:

There are 28 protocols and guidelines currently in effect, covering a wide range of medical services, such as routine pre-operative testing and prenatal ultrasound. This chart shows that a new protocol for blood testing reduced the number of microscopic tests that needed to be carried out. This was accomplished by recommending that laboratories do microscopic tests only when ordered by physicians for specific reasons, rather than routinely. This freed up resources for other needed medical services.

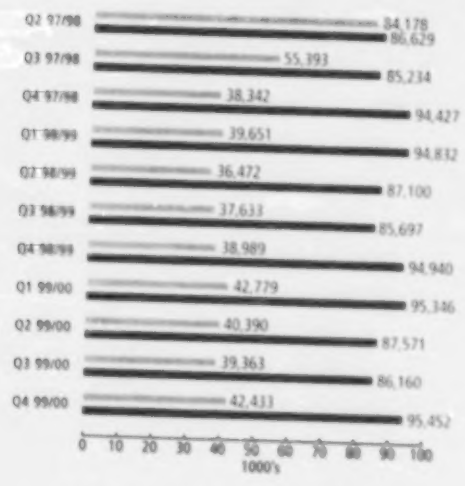
ESTIMATED CHANGES IN EXPENDITURES DUE TO GUIDELINES AND PROTOCOLS



Source: Management Support Branch, Strategic Planning and Development, Medical Services Plan, August 17, 1999.

BY REDUCING UNNECESSARY OR INAPPROPRIATE USE OF HEALTH SERVICES, MORE RESOURCES ARE AVAILABLE FOR THINGS THAT DO MAKE A POSITIVE DIFFERENCE TO THE HEALTH OF BRITISH COLUMBIANS.

ESTIMATED REDUCED UTILIZATION AND EXPENDITURE DUE TO PROTOCOL FOR ERYTHROCYTE SEDIMENTATION RATE



Source: Discharge Abstract Database.

The cost per Erythrocyte Sedimentation Rate test is $2.25. In 1996/1997, the year prior to the introduction of the protocols, there were 344,687 paid services. In 1999/2000 this number was reduced to 166,171 paid services. The cost in 1996/1997 was $775,545, in 1999/2000 this shrunk to $372,223, a cost reduction of 48 per cent.

While not all guidelines and protocols result in reduced costs, and may in some cases increase utilization, the overall impact of this initiative has been a more appropriate use of resources.

The MSC and the BCMA are currently working on further guidelines to maintain this initiative. These include the diagnosis and management of sore throat and the use of homocysteine measurement in the evaluation of heart disease.

B.C. Government Health Care Spending

The following charts present the amount spent on health care in British Columbia in 1998/1999 and 1999/2000, from several perspectives. Ministry expenditures increased by 7.9 per cent during 1999/2000, to $7.965 billion. However, the Ministry of Health is not the only ministry that spends money on health care; the third column indicates that other ministries spent an additional $310 million on health care, based on data from the Canadian Institute for Health Information (CIHI). For the same time period, CIHI data also lets us examine the levels of other public

HEALTH CARE SPENDING IN B.C. (MILLIONS OF DOLLARS) 1998/1999 – 1999/2000

	MINISTRY OF HEALTH	OTHER B.C. GOVERNMENT MINISTRIES	OTHER PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
1998/99	$7,383	$456	$558	$3,303	$11,700
1999/00	$7,965	$310	$589	$3,349	$12,213
			PERCENTAGE CHANGE (%)		
1999/00	7.9%	-32.1%	5.6%	1.4%	4.4%

Source: Canadian Institute for Health Information calendar year data have been converted from calendar years to fiscal years for comparison purposes.

HEALTH CARE SPENDING IN B.C. (DOLLARS PER PERSON) 1998/1999 – 1999/2000

	MINISTRY OF HEALTH	OTHER B.C. GOVERNMENT MINISTRIES	OTHER PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
1998/99	$1,843	$114	$139	$825	$2,921
1999/00	$1,973	$77	$146	$830	$3,025
		PERCENTAGE CHANGE (%)			
1998/00	7.0%	-32.7%	4.7%	0.6%	3.6%

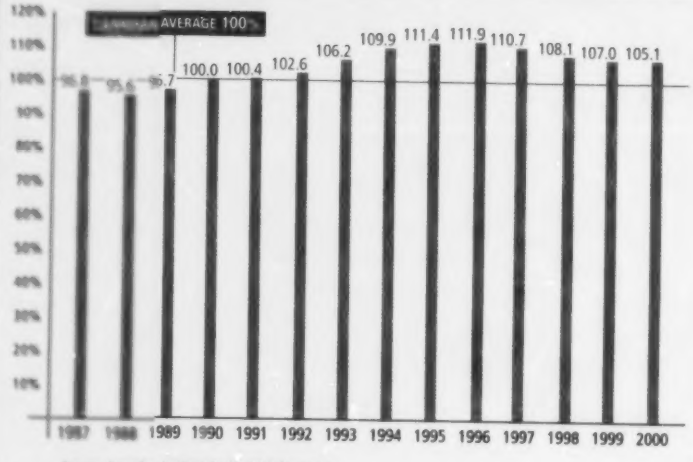
Source: Canadian Institute for Health Information calendar year data have been converted from calendar years to fiscal years for comparison purposes.

sector expenditures consisting of municipal and federal government direct spending on health care, as well as Workers' Compensation Board expenditures. In addition, CIHI data enables us to examine private sector contributions to total health care spending, such as commercial and not-for-profit insurance plans, and out-of-pocket expenses.

National Comparison

The following table shows the British Columbia provincial government's per person spending on health as a percentage of the Canadian average. Over this 16-year period, B.C. moved from below the Canadian average to consistently above average in health spending.

B.C GOVERNMENT HEALTH SPENDING PER PERSON AS A PERCENTAGE OF CANADIAN AVERAGE, 1987-2000



Source: Canadian Institute for Health Information.
Note: Figure for 1999 and 2000 are projections.

PROTECTING MEDICARE AND ESSENTIAL HEALTH SERVICES

- **Increased Health Care Funding** – The Ministry of Health increased funding in 1999/2000 to ensure quality, accessible and affordable health care services for all British Columbians.
  - The ministry budget increased by $615 million to enhance health services. B.C.'s health budget has increased for eight consecutive years from $5.5 billion in 1991/1992 to $8 billion in 1999/2000 for a total increase of $2.5 billion or 45 per cent. This year, the operating budget increased by $478 million and the capital budget increased by $137 million. Priorities for new funding included recruiting more nurses, improving facilities and enhancing health services.
  - Funding of $4.38 billion was allocated to local health authorities to deliver acute and continuing care, mental health and preventive health services for the year. Increased funding was provided for more radiotherapy and chemotherapy cancer treatments, more screening mammograms, and more cardiac, hip and knee surgeries. Funding was also provided to purchase additional long-term beds for patients so acute-care hospital beds could be available for other patients in hospitals across the province.
  - Health authorities received $100 million to prepare hospital facilities and computers for Y2K.
  - An $8.9-million funding increase was provided for renal services to meet the growing demand for kidney dialysis services in the province.
- **Establishing Guidelines and Protocols** – The Ministry of Health supported the B.C. Medical Association in developing guidelines for effective practice:
  - The ministry funds and supports the Guidelines and Protocols Initiative in partnership with the B.C. Medical Association. An advisory committee of over 80 physicians coordinates the initiative. The physicians aim to guide their colleagues in effective practice by providing recommendations for diagnosing and treating common conditions, based on evidence and consensus by B.C. doctors. In 1999/2000, the advisory committee developed five new medical guidelines now adopted by the Medical Services Commission, and part of the total 28 guidelines and protocols in effect.

B.C.'S HEALTH BUDGET HAS INCREASED FOR EIGHT CONSECUTIVE YEARS FROM $5.5 BILLION IN 1991/1992 TO $8 BILLION IN 1999/2000 FOR A TOTAL INCREASE OF $2.5 BILLION OR 45 PER CENT.

A NUMBER OF INITIATIVES WERE UNDERTAKEN TO REDUCE PATIENT WAITS FOR SURGERY AND OTHER TREATMENT SERVICES.

- **B. C. Medical Association Agreement** – The ministry and the B.C. Medical Association reached a new working agreement and an agreement on the budget for doctors' services for 1999-2000, as well as for the next fiscal year expiring on March 31, 2000.

- **Recruiting Nurses** – $50 million in funding was announced to recruit and retain more nurses for B.C. hospitals and long-term-care facilities. Steps taken include:

  - The government committed funding to hire 400 registered nurses in 1999/2000, as part of a two-year plan to hire 1,000 nurses in B.C. Additional funding was allocated to increase the number of licensed practical nurses and care aides working in continuing care facilities.

  - Health Match BC helps rural and remote communities to recruit and retain health professionals. Health Match BC established a recruitment service for nurses and began planning a campaign to recruit nursing staff in rural areas.

  - A recruitment and retention task force was created to develop new human resource policies to promote nursing as a more attractive career choice. To attract young people to nursing, new television advertising was launched.

- **Health Human Resources** – In addition to addressing the nursing shortage, action was taken in other areas to ensure an adequate long-term supply of health care workers:

  - Federal, provincial and territorial health ministers agreed to create a national health human resources strategy. British Columbia is chairing the advisory committee to develop an innovative, national approach to address the health care needs of Canadians. The committee is to prepare new approaches and strategies for the organization of health services and distribution of health care providers, particularly nurses and physicians.

  - $619,500 in health-care scholarships were awarded to help registered nurses, paramedical professionals and health support workers upgrade their knowledge and skills.

- **Reducing Wait Times** – A number of initiatives were undertaken to reduce patient waits for surgery and other treatment services:

  - New funding of $10.76 million provided over 700 more cardiac surgeries and reduced wait times for patients.

  - $4.7 million in funding was approved for a new catheterization lab to be built at Royal Columbian Hospital in New Westminster. In addition, funding was approved to upgrade cardiac equipment at Royal Columbian Hospital and Victoria's Royal Jubilee Hospital.

- $6 million in new funding provided 1,000 more hip and knee replacement surgeries this year and reduced patients' wait times. The funding went to hospitals in Greater Vancouver, the Fraser Valley, the Kootenays, the Okanagan, the Thompson region, Victoria and Vancouver Island, the North West and the Northern Interior.
- A new Web site and Surgical Wait List Registry were developed to inform patients and doctors of wait times for specialists across the province, covering 20 categories of surgeries and treatments like cancer services, cardiac surgery and hip replacements. The Web site is updated monthly and will be expanded to include every hospital in B.C. performing 1000 or more surgeries per year. The registry is monitored by a provincial wait list coordinator and managed by ministry staff.

- **New Health Care Equipment** – The ministry provided health authorities across the province with $45 million to purchase new equipment, including CT scanners, patient monitoring systems, x-ray machines and medical equipment.

- **Progress on Mental Health Reform** – The provincial government approved further action and developed initiatives on mental health reform:
  - Changes to the *Mental Health Act* came into effect to ensure more responsive care to people with debilitating mental illnesses. The changes included protecting patients' rights in the Act, reducing re-hospitalization for people with serious mental illnesses, formally involving families in the treatment process, and clarifying and simplifying the *Mental Health Act*.
  - The ministry, in collaboration with health authorities, developed documents outlining seven best practices in mental health services.
  - The government announced a $5.7-million package of programs to support B.C.'s mental health plan. This included $2.98 million to expand community mental health services and to relieve pressure on emergency and acute care psychiatric facilities. In addition, funding of $2.73 million provided intensive community support for people with mental illness.
  - An Early Psychosis Initiative was implemented with ministries to assist health authorities in the assessment and early treatment of people with schizophrenia and other mental illnesses. Several initiatives were also developed to provide better psychiatric services in rural hospitals. In addition, over 100 housing units were developed for persons with mental health and other conditions that are barriers to securing housing.
  - One-time funding was provided for projects to improve services for women with mental illness as part of the B.C. mental health plan. The funding supported training, research and best practices on the needs of women with mental illness before, during and after pregnancy.

A MACLEAN'S MAGAZINE SURVEY IN 1999 FOUND THAT OVERALL BRITISH COLUMBIANS ARE THE HEALTHIEST OF ALL CANADIANS.

PROMOTING GOOD HEALTH

- **B.C. is Canada's Healthiest Province** – A *Maclean's* magazine survey in 1999 found that overall British Columbians are the healthiest of all Canadians. The report compared key health indicators, such as mortality rates, life expectancy and economic status, for 17 major centres across Canada. British Columbia ranked number one in the country in several key categories, including:
  - most physically active (27 per cent);
  - fewest smokers (24 per cent);
  - least overweight (27 per cent);
  - highest life expectancy for men (76.6 years); and
  - second highest life expectancy for women (82.1 years).
- **Declining Infant Mortality** – British Columbia's infant mortality rate dropped to an all-time low of 3.7 infant deaths per 1,000 live births in 1999 – a drop from the previous year's figure of 4.1. Since 1965, infant mortality has decreased by 80 per cent.
- **New Provincial Health Officer** –Dr. Perry Kendall was appointed as British Columbia's new Provincial Health Officer. The role of the Provincial Health Officer includes advising on health issues, producing an annual report on the health of the population, and reporting on progress toward the government's health goals.
- **Health Goals for British Columbia** – The Provincial Health Officer released a *Report on the Use of Provincial Health Goals in Regional Health Service Plans*. The report found that health authorities use B.C.'s health goals in their operational planning. The report also noted the need for common indicators and baseline data to report on progress towards achieving the provincial health goals. In addition, the Provincial Health Officer started preparing a report to assist health authorities and others to use B.C.'s health goals in their planning and initiatives.
- **Immunization Report** – The Provincial Health Officer released a report on immunization which presented 81 recommendations, including:
  - Offering publicly funded immunizations to all target groups recommended in the Canadian Immunization Guide, including adults over 65 and people with chronic illnesses or immune deficiencies.
  - More immunization on time for all infants and preschool children, and more influenza immunization for all risk groups.
  - Funding to expand hepatitis B immunization for all infants and children, pneumococcal immunization for people with chronic diseases in all age groups, and hepatitis A immunization for men who have sex with men.
  - Introducing chickenpox vaccine and acellular pertussis vaccine for adolescents.

- Managing the expected worldwide epidemic of influenza.
- Funding to continue developing a province-wide electronic registry for immunizations, communicable diseases and adverse reactions.
- Developing a plan to meet provincial goals and targets for immunization and for the control of vaccine-preventable diseases.

- **Immunization Initiatives** – Other ministry and health system initiatives on immunization in 1999/2000 included:
  - For the second year, the ministry continued to offer pneumococcal vaccine to all persons 65 years and older to protect against pneumococcal bacteria, which is a cause of pneumonia and serious illness in elderly people. Almost forty per cent of those eligible received the vaccination.
  - The electronic immunization record system to increase child immunization levels was implemented in seventeen of the eighteen health regions by the ministry.
  - The ministry received funding from Health Canada for participation in the National Diabetes Surveillance System, which will enhance the ministry's capacity to create and use surveillance data.
  - A new advisory group, which reports to the British Columbia Centre for Disease Control, was formed to provide critical review of new vaccine products and programs.

- **Public Health Information** – The ministry implemented major initiatives to enhance access to public health information and health care services to promote the well-being of British Columbians:
  - Recognized by Health Canada as a leader in the field of surveillance, B.C.'s Public Health Information System was transferred from the ministry to the British Columbia Centre for Disease Control, which developed a plan to implement the information system across the country.

- **PharmaNet Expansion** – A pilot project was launched to test the benefits of extending PharmaNet, B.C.'s pharmacy computer network, to doctors' offices to assist doctors in prescribing medication for their patients.

- **Self-care Pilot Project** – Partnerships for Better Health, a 1997-1999 pilot project, was successful in actively involving 20,000 Victoria residents in their own health care. First-year results of the two-year pilot project indicated that more than 75 per cent of participants consulted the project's handbook to answer health questions. Participants reported feeling more confident in discussions with their doctors and in making health care decisions. The project's health support line handled 1,634 calls in 1998, and 84 per cent of callers followed the advice of the nurse answering inquiries. First-year results also indicated public use of the health support line resulted in increased confidence regarding self-care and decreased emergency visits for minor conditions.

PARTICIPANTS INDICATED INCREASED CONFIDENCE REGARDING SELF-CARE AND DECREASED EMERGENCY VISITS FOR MINOR CONDITIONS.

- **Primary Care Demonstration Project** – Seven project practices were established throughout the province to test innovative ways to improve the accessibility, integration and coordination of primary care delivery. Key features of the primary care demonstration practices include a multidisciplinary team-based approach to health care delivery, advanced clinical information management systems, and blended funding in place of payment solely based on medical services provided.
- **Primary Health Care Office** The Primary Health Care Office has developed the vision, goals, objectives and framework for primary health care in B.C. Part of its role is to identify urban and rural communities who are interested in developing primary health care centres. The office continued to provide support to health authorities, communities and physician practices interested in establishing primary health care centres focused on interdisciplinary team practice, broad-based community involvement, and prevention and health promotion.

ENHANCING REMOTE AND RURAL HEALTH CARE

- The Provincial Coordinating Committee on Remote and Rural Health Services, established in 1998, continued to make recommendations to the Deputy Minister of Health and coordinate initiatives on health care delivery in remote and rural communities.
- The Rural Agreement established a Joint Standing Committee to address ways of enhancing the delivery of rural health care through emerging technologies such as telecare. The committee comprises three members appointed by the B.C. Medical Association and three members appointed by the provincial government. It has authority to allocate $600,000 in annual funding for contingencies and innovation. The Northern and Isolation Allowance Program provides a fee premium for physicians who live, work and take calls in 101 eligible rural and isolated communities. The allowance was paid to 405 physicians in 1999/2000.
- The Emergency Medical Coverage Program provides on-call stipends and enhanced continuing medical education funds to family doctors and general practice specialists in rural and remote communities. In 1999/2000, 83 communities in B.C. received support through the program.

- Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for 1207 visits by family doctors and specialists to 44 rural communities, paying for a travel time honorarium, travel expenses and accommodation costs.
- The Northern and Rural Locum Program was established to assist physicians practicing in small communities to secure subsidized Continuing Medical Education and vacation relief. The program supported 2,802 locum days in 232 assignments during 1999/2000.
- Health Match BC helped 24 doctors to locate permanently in rural and remote communities in 1999. In addition, 11 locums were provided on a temporary basis to communities attempting to recruit permanent physicians.
- The ministry funded an evaluation of RN First Call – a pilot program which trained 229 RNs in rural hospital emergency departments to respond to and treat a number of health concerns without requiring physician attendance. An evaluation was completed and the overall trend suggests the program has the potential to provide an appropriate service to patients who present to emergency settings for non-urgent reasons.

- **Food safety** – The provincial government took action to enhance food safety protections:
  - A new food premises regulation was introduced by the ministry to control the cause of food-borne illness more effectively and to ensure the delivery of safe, high-quality food to consumers. The new regulation places more responsibility on the industry to take actions to prevent food-borne illness. Health inspectors will focus on the areas of highest risk to public health, targeting food preparation and storage, and premises with a history of non-compliance with regulations.
  - The ministry conducted a B.C. Nutrition Survey of adults' dietary habits to assess population nutritional status and to plan nutritional programs, regulations and policies. Survey data will be available in 2002.
  - A Well Protection Toolkit was developed in cooperation with the Ministry of Environment, Lands and Parks and workshops were held to facilitate support by industry and local government for compliance with the Safe Drinking Water Regulation.

THE NORTHERN AND RURAL LOCUM PROGRAM WAS ESTABLISHED TO SUPPORT PHYSICIANS IN SMALL COMMUNITIES.

- **Tobacco Strategy** – Several steps were taken to prevent tobacco use and to strengthen B.C.'s tobacco reduction efforts:
  - The provincial government announced that it would amend B.C.'s tobacco legislation and continue its lawsuit against tobacco companies to recover health care costs associated with smoking. In addition, changes to the *Tobacco Sales Act* authorize the province to publish the names of suspended tobacco retailers.
  - To reduce tobacco use among youth, the Kick the Nic 2000 quit smoking program was announced and offered free to interested teenagers by health care providers and teaching professionals at schools and community agencies. In January 2000, the ministry kicked off National Non-Smoking Week with the release of *Gasp* magazine – a new magazine developed for teens which uses graphic images, personal stories and factual information to communicate the dangers of smoking to youth. The ministry also funded 29 tobacco reduction pilot projects in aboriginal communities.
- **Screening Mammography** – Expanded and improved screening mammography services included:
  - Increased funding for the Screening Mammography Program of British Columbia totalled $10.77 million to expand services to 240,000 screens in 1999/2000. Expanded services included the opening of new screening mammography sites at Victoria General Hospital and Langley Memorial Hospital.
- **HIV/AIDS Prevention** – Base funding for community HIV/AIDS programs and services across British Columbia was increased by $750,000 to more than $10 million a year – the highest per capita funding in Canada. The ministry continued to purchase and distribute needles, syringes, condoms and lubrication to needle exchanges across the province, which has been an essential cost-effective intervention for HIV/AIDS. The ministry continued to provide guidelines and requirements to health authorities for developing HIV/AIDS plans on the distribution of contracts and services. An HIV/AIDS Advisory Committee provided policy advice and reported to the Minister of Health.
- **Diabetes Prevention** – The ministry announced plans to develop a comprehensive diabetes prevention and control strategy for British Columbia. As a first step, preliminary research was conducted including a literature review and interviews with key informants with expertise in diabetes prevention, education and management. Aboriginal people were among the key informants.

IMPROVING ACCESS TO HEALTH CARE FOR POPULATIONS AT RISK OF POOR HEALTH

- **Supporting Seniors** – B.C.'s Senior Citizen Counsellor program was transferred from the Ministry of Human Resources to the Office for Seniors in the Ministry of Health. Located throughout the province, some 175 volunteer counsellors answer more than 6,000 requests per month from seniors who need assistance with health, housing, transportation, elder abuse or financial issues.

- **Community Care Facilities** – The ministry has been developing outcome-based regulations to continue promoting the health of vulnerable children, youth and adults cared for in licenced community care facilities. Consultation took place to develop a revised *Community Care Facility Act,* governing the licensing of community care facilities in B.C. A booklet titled *Choosing a Care Facility* was also developed to help people choose an adult residential care facility under the new legislation.

- **Not-for-Profit Continuing Care** – A steering committee was established to expand the role of not-for-profit organizations in developing and operating continuing care facilities.

- **Cardiovascular Disease Prevention** – Health Canada approved an additional five years of funding for the British Columbia Heart Health Program, Dissemination Phase, to enhance the capacity of health authorities to plan and deliver community-based, cardiovascular disease prevention programs. Key initiatives have included regional grants for needs assessments, a scan of prevention activities in each health region, training workshops for health professionals and sponsorship of conferences, such as the first International Conference on Women, Heart Disease and Stroke. The Cardiovascular Disease Prevention unit initiated the development of a provincial prevention strategy, involving interviews with stakeholders from many regions and organizations in the province.

- **Women's Health** – The following initiatives were taken to address women's health concerns and their unique needs:

  - The Minister's Advisory Council on Women's Health and Children's and Women's Hospital and Health Centre of British Columbia sponsored a symposium on improving services for aboriginal women with alcohol and other drug addictions. The symposium took place in Vancouver in March 2000.

  - Workshops to promote awareness of and action on women's health issues were conducted in six regions throughout B.C. Workshop topics included health issues for aboriginal women, gender inclusive analysis, medicalization of women's health, violence against women, women and mental health, and women and substance misuse.

- Projects and publications on women's health were developed for women, the public and service providers. In collaboration with the Women's Health Bureau, the Women's Health in Midlife Project was initiated to help women make informed choices about managing key mid-life health issues through health education and community action. The project included educational tools and products available through B.C. Women's Hospital and Health Centre.

- **Children's Health** – $1.4 million in new funding was provided to the pediatric medical oncology and hematology unit of Children's and Women's Health Centre of B.C. for a neuro-oncology unit for children who have brain or spinal cord cancer. The funding also provided new nursing and outreach positions to enhance patient care and the multidisciplinary team in the oncology clinic, where up to 50 young patients a day receive treatment.

- **Rural and Remote Communities** – Several steps were taken to strengthen health services in rural and remote areas of the province:
  - The ministry provided funding for an evaluation of the Emergency Medical Coverage Program to review the recruitment and retention of physicians, access to care, impact on physicians and health authorities in Northern Isolation Allowance (NIA) communities, and costs of the program.
  - In addition, the ministry provided funding of $250,000 for training six family physicians, primarily in rural areas, to address the needs of people with mental illness.

THE MINISTRY AND HEALTH AUTHORITIES ARE DEFINING STANDARDS AND PERFORMANCE MEASURES TO TRACK AND COMPARE HEALTH SERVICES IN THE PROVINCE. HEALTH SERVICE PLANNING IS A KEY ACCOUNTABILITY MECHANISM BETWEEN THE MINISTRY AND HEALTH AUTHORITIES.

ESTABLISHING A STRONG AND EFFECTIVE GOVERNANCE AND DELIVERY SYSTEM

- **Health Authority Accountability** - The ministry and health authorities are defining standards and performance measures to track and compare health services in the province, as one component of health authority accountability to the ministry. Health service planning is a key accountability mechanism between the ministry and health authorities. The Regional Health Boards submitted their first health service plans to the ministry for review and approval in 1999-2000. The plans focus on priority health care requirements and planned strategies and activities. The Community Health Services Societies and Community Health Councils will submit their first plans to the ministry in 2000-2001. These reports will be used by the ministry to inform the public about the status of the health system.

- **Health Authority Board Members** – The Appointment Guide for Health Authorities was revised and included changes identified by health authorities to improve the appointment process.

- **Traditional Chinese Medicine** – In 1999/2000, the government announced that B.C. would be the first province in Canada to regulate the full range of traditional Chinese medicine therapies, based on recommendations made by the Health Professions Council. The council review of traditional Chinese medicine included extensive research, as well as consultation with practitioners and consumers.
- **Central Transfusion Registry** – The Central Transfusion Registry is operated by the Provincial Blood Coordinating Office. Hospitals province-wide began to report to the registry, which tracks the disposition of blood and blood products. The registry improved management of the utilization of blood and blood products, as well as assisting in the future notification of transfusion recipients.
- **Informed Consent** – In accordance with a recommendation by the Krever Commission, the ministry directed hospitals to develop and implement an informed consent procedure for administering blood and blood products to patients. The Provincial Blood Coordinating Office organized the development of guidelines and informational materials for physicians and patients, which were distributed to hospitals.

REJUVENATING THE HEALTH CARE SYSTEM FOR LONG-TERM SUSTAINABILITY

- **Innovations in Health Care Management** –
  - In 1999/2000, the ministry developed Canada's most comprehensive information standards for the electronic ordering and reporting of lab tests. The ministry is working with both public and private labs to implement these standards.
  - The ministry continued to explore alternative funding options for physicians such as salaried and service agreement contracts, particularly in teaching hospitals and primary care settings. During 1999-2000, the Alternative Payments program consolidated most of its funding to regional authorities to improve integration of physician funding with regional priorities. New primary care contracts were implemented in the Southern Gulf Islands, Fraser Lake and Robson Valley. New specialist contracts were implemented in Terrace, Prince George and the East Kootenays. Approximately 103 agencies were funded through alternative payment arrangements at 500 sites in B.C., with 2,000 physicians receiving some or all of their income through the agencies.
  - A Health Registry, introduced in 1999/2000, assists hospitals, care providers and large employer groups to self-manage employee enrollment in the ministry's Medical Services Plan. The registry reduces delays in enrollment and maintains records of individual registrations and premium status.

B.C. WOULD BE THE FIRST PROVINCE IN CANADA TO REGULATE THE FULL RANGE OF TRADITIONAL CHINESE MEDICINE THERAPIES, BASED ON RECOMMENDATIONS MADE BY THE HEALTH PROFESSIONS COUNCIL.

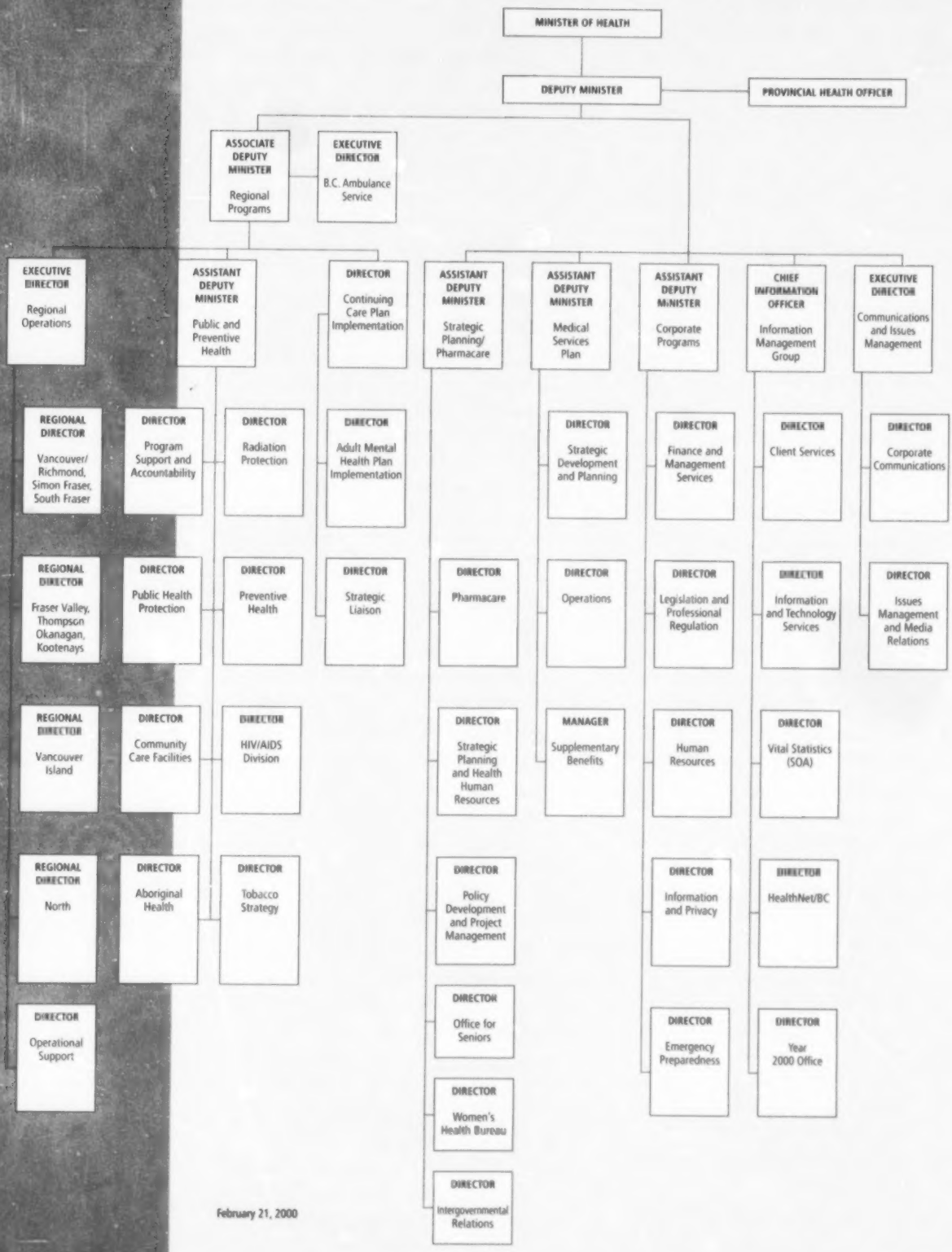
AN INTEGRATED HEALTH PLANNING DATABASE – HNDATA – WAS CREATED FOR RESEARCHING AND PLANNING HEALTH SERVICES AT THE REGIONAL AND PROVINCIAL LEVELS, AND FOR MANAGING HEALTH CARE RESOURCES.

- An integrated health planning database – HNData – was created for use by the ministry and health authorities. The database will be used for researching and planning health services at the regional and provincial levels, and will assist in managing health care resources.
- The ministry participated in a federal, provincial and territorial working group to address issues regarding the need to protect personal health information.
- The ministry established an Emergency Preparedness Branch, an integral part of its Y2K initiative. By working with health authorities, ministry programs, other ministries and agencies, the branch is fostering disaster response planning and management capability at critical points in the health care system.

- **New and emerging treatments** – The ministry supported and expanded innovative treatments in several areas of health care:
  - Increased annual funding of $535,000 allowed St. Paul's Hospital to nearly double the number of beds in its in-patient eating disorder program.
  - $500,000 in funding was provided for additional brachytherapy treatment for men whose cancer is localized in the prostate gland. Brachytherapy is a relatively new form of radiotherapy that implants radioactive seeds into the prostate. Treatment is completed in one visit and there are fewer side effects.
  - $439,000 in funding was provided for the Hereditary Cancer Program at the B.C. Cancer Agency. The program offers genetic counselling and education to individuals with a strong family history of breast, ovarian or colon cancer.
  - Funding of $185,000 was provided for the treatment of 20 patients using deep brain stimulation technology for Parkinson's disease, multiple sclerosis and other movement disorders.
  - Three asthma education projects were undertaken to increase the appropriate use of medications by educating patients, physicians, pharmacists and other health professionals. Patients were instructed on how to recognize asthma symptoms and triggers, improve medication use, and monitor the effectiveness of medications.
  - A new drug treatment for hepatitis C, Rebetron, was covered by the provincial Pharmacare program for British Columbians.
- **Health Capital Projects** – A wide range of capital construction projects were undertaken to provide new and improved health care facilities for British Columbians. Major capital projects supported by the ministry in 1999/2000 included:
  - Construction of a new building for essential diagnostic and treatment services at the Royal Jubilee Hospital in Victoria began as part of a $101-million redevelopment of the hospital.
  - $152.2 million was approved for the interior construction of floors 4-15 of the Laurel Street Pavilion tower at Vancouver General Hospital.

- Funding of $34.77 million was approved to replace Kitimat General Hospital. The new Kitimat Health Centre will house 22 acute-care beds and 35 multi-level care beds, as well as community health services.
- Construction began on the new $46.7-million expansion to the Vancouver Island Cancer Centre in Victoria. The new centre will increase the treatment capacity by 1,500 patients per year and will mean faster treatment closer to home for residents of Vancouver Island.
- Work began to replace West Coast General Hospital in Port Alberni with a 53-bed, acute-care hospital, with emergency and ambulatory care services. A 32-bed, multi-level care facility will replace the current extended care unit.
- Funding of $25.25 million was approved to replace Mount St. Mary Hospital in Victoria with a new 150-bed, multi-level care facility.
- Funding of $6.72 million was approved for a new South Similkameen Health Centre to expand emergency and outpatient services and provide a broad range of community care services in Keremeos.
- $14 million was approved to build a new multi-level-care facility of 100 beds to replace Fair Haven United Church Home and relieve pressure on acute-care beds and reduce wait lists for residents in the Vancouver/ Richmond health region.
- Funding of $11.1 million was announced to replace Yuculta Lodge in Campbell River with a new 100-bed, multi-level care facility to relieve pressure on acute-care beds and reduce wait lists for residents.
- The ministry announced that a new $4.3 million Cormorant Island Community Health Centre will be built to replace St. George's General Hospital, improving access to health services and providing better patient care for Alert Bay residents.
- Funding of $6.89 million was approved to upgrade and expand Cooper Place to provide quality long-term care for seniors in Vancouver's Downtown Eastside. The expansion will add 36 new beds, built to multi-level care standards, for a total of 99 beds.
- Funding of $4.7 million was announced to expand the Three Links Care Centre to provide state-of-the-art, long-term care for 89 seniors in the Lower Mainland.
- Funding of $1.5 million was approved to renovate the emergency department at Burnaby Hospital. This will provide a mental health observation room and numerous other improvements.
- Funding of almost $1.5 million was provided to add 10 multi-level care beds to Victorian Hospital in Kaslo.
- In addition, more than $19 million was approved for minor capital projects, including building and mechanical upgrades, fire safety improvements, and new smaller facilities for long-term care and mental health services.

APPENDIX 1 – MINISTRY ORGANIZATIONAL CHART



February 21, 2000

APPENDIX 2 –

ACTS AND PROFESSIONS UNDER THE JURISDICTION OF THE MINISTER OF HEALTH AND MINISTER RESPONSIBLE FOR SENIORS.

ACTS

Access to Abortion Services Act
Anatomy Act
Chiropractors Act
Community Care Facility Act
Continuing Care Act
Dentists Act
Forensic Psychiatry Act
Health Act
Health Authorities Act
Health Care (Consent) and Care Facility (Admission) Act [parts in force Feb 28/00]
Health Emergency Act
Health Professions Act
Health Research Foundation Act
Health Special Account Act
Hearing Aid Act
Hospital Act
Hospital District Act
Hospital Insurance Act
Human Tissue Gift Act
Marriage Act
Meat Inspection Act
Medical Practitioners Act
Medicare Protection Act
Mental Health Act
Milk Industry Act (Section 12, except tank milk receiver licences)
Ministry of Health Act
Name Act
Naturopaths Act [repealed effective Jan 1/00]
Nurses (Registered) Act
Optometrists Act
Pharmacists, Pharmacy Operations and Drug Scheduling Act (except Part 8)
Podiatrists Act
Psychologists Act [repealed effective Jan 1/00]
Public Toilet Act
Seniors Advisory Council Act
Tobacco Damages and Health Care Costs Recovery Act
Tobacco Fee Act [not in force]
Tobacco Sales Act
Venereal Disease Act
Vital Statistics Act
Wills Act (Part 2)

PROFESSIONS

Acupuncturists
Chiropractors
Dental Hygienists
Dental Technicians
Dentists
Denturists
Emergency Medical Assistants
Hearing Aid Dealers (including audiologists in private practice)
Licensed Practical Nurses
Massage Therapists
Medical Practitioners
Midwives
Naturopaths
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physical Therapists
Podiatrists
Psychologists
Registered Nurses
Registered Psychiatric Nurses

APPENDIX 3 – 1999 LEGISLATIVE CHANGES

Eighteen Acts administered by the ministry were amended, repealed or passed during the 1999 Sitting of the Legislative Assembly. The most significant changes include:

HEALTH STATUTES AMENDMENT ACT, 1999 (BILL 76)

- The *Naturopaths Act* and the *Psychologists Act* were repealed. Naturopathic physicians and psychologists are now regulated, along with 11 other health professions, under the *Health Professions Act*. In the public interest, the *Health Professions Act* establishes a framework for consistent regulation of self-governing health professions.
- Several streamlining amendments were made to remove obsolete provisions from the *Community Care Facility Act*, the *Health Act* and the *Hospital Act*. The *Hospital (Auxiliary) Act* was repealed entirely.

ADULT GUARDIANSHIP STATUTES AMENDMENT ACT, 1999 (BILL 92)

- Several minor amendments were made to the *Health Care (Consent) and Care Facility (Admission) Act*, including the establishment of one provincial review board instead of numerous regional review boards and enabling health care providers and advocacy organizations to request a review. The *Health Care (Consent) and Care Facility (Admission) Act* recognizes an adult's right to give or refuse consent and establishes a legal framework for giving or refusing consent when an adult is unable to do so.
- The *Health Care (Consent) and Care Facility (Admission) Act* came into effect February 28, 2000 along with the three other statutes in the adult guardianship legislative package originally enacted in 1993, which comprised the *Adult Guardianship Act*, *Representation Agreement Act*, *Public Guardian and Trustee Act*.

MISCELLANEOUS STATUTES AMENDMENT ACT (NO. 3), 1999 (BILL 97)

- Several sections of the *Tobacco Damages and Health Care Costs Recovery Act* dealing with subrogated claims were repealed in July 1999. These provisions became redundant after the Government of British Columbia commenced a direct legal action against the tobacco industry in 1998 to recover health care costs incurred as a result of tobacco-related illness.
- The *Tobacco Sales Act* was amended, along with complementary amendments to the *Tobacco Tax Act* administered by the Ministry of Finance and Corporate Relations, to clarify the legal authority and process for exchanging information between the ministries for the purposes of enforcing the prohibition against selling tobacco to minors.

APPENDIX 4 – MINISTRY EXPENDITURE STATEMENT

MINISTRY OF HEALTH EXPENDITURES BY PRINCIPAL PROGRAMS

	1998/1999 ACTUALS	1999/2000 ACTUALS
Emergency Health	137,988,000	144,266,112
Adult Mental Health	326,582,000	341,152,749
Public and Preventive Health	137,871,000	174,515,012
Acute and Continuing Care	4,129,236,000	4,425,307,164
MSP	1,847,504,000	1,955,957,769
Pharmacare	504,258,000	568,944,833
Debt Servicing	173,947,000	213,224,517
Other	126,006,000	141,908,764
Total	**7,383,392,000**	**7,965,276,920**

NOTES:

1) Expenditures for 1998/1999 have not been restated to reflect major program reallocations and are presented here for comparative purposes only.

2) Other includes: Minister's Office, Corporate Services, Vital Statistics, Medical and Health Care Services Special Account, Statutory Expenditures and adjustments for the capitalization of assets and depreciation expense.

3) 1998/1999 and 1999/2000 figures are per Public Accounts publications. Figures refer to Ministry of Health expenditures only. Health related expenditures undertaken by other ministries are excluded from this schedule.

4) Debt Servicing includes both Debt Servicing contributions and Amortization of Prepaid Capital Advances.

STATEMENT OF OPERATIONS

MEDICAL SERVICES COMMISSION STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2000 (UNAUDITED)

(THOUSANDS OF DOLLARS)	2000	1999
EXPENDITURE		
Service Costs	$	$
Medical Care	1,807,353	1,699,443
Supplementary Care	122,943	120,938
	1,930,296	1,820,381
Administration		
General Office	5,969	6,573
Salaries	19,693	20,550
	25,662	27,123
	1,955,958	1,847,504
CONTRIBUTIONS (Note 3)		
Premium Revenue	868,263	876,047
Premium Assistance	362,947	359,225
General Contributions	724,748	612,232
	1,955,958	1,847,504

The accompanying notes are an integral part of this financial statement.

Approved on behalf of the Commission:

Janet E. McGregor
DEPUTY CHAIR, MEDICAL SERVICES COMMISSION

MEDICAL SERVICES COMMISSION NOTES TO FINANCIAL STATEMENT

1. THE COMMISSION

The Medical Services Commission was established, effective July 1, 1968, by the Government of the Province of British Columbia under the *Medical Service Act* and Regulations, to administer and operate the Medical Services Plan.

The legal authority for the Medical Services Commission to administer and operate the Medical Services Plan is the *Medicare Protection Act*.

Under Section 5(4) of the *Medicare Protection Act*, the Commission is a division of the Ministry of Health and Ministry Responsible for Seniors. Medical Services Plan premiums and expenditures are included within the Province's Consolidated Revenue Fund Statement of Revenue and Expenditure, which is audited annually by the Auditor General of British Columbia.

2. SIGNIFICANT ACCOUNTING POLICIES

The Statement of Operations is prepared for the purpose of presenting the expenditures of the Plan and contributions by subscribers and the Province.

The expenditures and contributions are recorded on an accrual basis.

The cost of furniture and equipment is charged to administration expense in the year of acquisition.

The Province of British Columbia pays certain administration, accommodation, data processing and systems salary costs associated with the operation of the Commission.

Service costs include payments for eligible services provided by medical practitioners and other health care practitioners on a fee for service basis according to fee schedules approved by the Commission, and payments on a contract, salaried or sessional basis. The expenditures include estimates of claims, for services performed in the year, that were unpresented or unprocessed at March 31, 2000.

3. CONTRIBUTIONS

Premium revenue consists of the Medical Services Plan premiums paid by subscribers.

Premium assistance represents the value of subsidy provided by the Province on behalf of eligible persons.

General contributions represent the net amount paid by the Province to fully meet the expenditure of the Commission.

APPENDIX 6 – REVENUE AND ACCOUNTS RECEIVABLE PROGRAMS

MEDICAL SERVICES PLAN

Collection of Overdue MSP Premiums Receivable

FISCAL YEAR	TOTAL REVENUE	COLLECTIONS NOTICES	COLLECTIONS AND CREDIT ADJUSTMENTS*
1999/00	$868,263,000	$48,760,327	$82,900,912
1998/99	876,047,000	60,495,000	44,242,000
1997/98	881,826,000	54,384,000	33,652,000
1996/97	853,262,000	35,338,000	15,450,000

Aging of MSP Premiums Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2000	$75,802,663	$20,371,100	$7,045,567	$3,482,546	$44,903,450
March 31, 1999	83,973,084	20,453,668	7,454,562	2,725,694	53,339,160
March 31, 1998	54,913,907	13,682,583	9,187,698	1,679,532	30,364,094
March 31, 1997	29,945,709	12,464,434	4,237,681	1,089,114	12,154,480

MSP Premiums Receivable – Turnover and Days Billings Uncollected

Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for MSP Premiums Receivable was 11.5 times for fiscal 1999/00; 10.4 times for fiscal 1998/99; 16.1 times for fiscal 1997/98. An increase in turnover indicates that MSP Premiums Receivable are collected more rapidly.

Days billings uncollected is another indication of the speed of collecting accounts receivable. 1999/00 – 32 days; 1998/99 – 35 days; 1997/98 – 23 days.

**Collections and Credit Adjustments include premiums paid, and adjustments that reduce indebtedness.*

BC AMBULANCE SERVICES

Collection of Overdue Ambulance Service Fees

FISCAL YEAR	TOTAL REVENUE	COLLECTION NOTICES	COLLECTION AND CREDIT ADJUSTMENTS**
1999/00	$24,372,818	$10,272,287	$10,752,966
1998/99	23,496,000	13,349,000	7,347,000
1997/98	22,445,000	9,542,000	4,818,000
1996/97	18,706,000	7,831,000	4,583,000

Aging of Ambulance Fees Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2000	$11,047,934	$1,796,950	$913,085	$386,409	$7,951,490
March 31, 1999	9,488,913	1,265,355	408,006	308,543	7,507,009
March 31, 1998	10,344,927	2,575,413	954,471	380,966	6,434,077
March 31, 1997	7,878,508	1,100,680	611,135	325,384	5,841,299
March 31, 1996	7,949,575	1,108,115	628,751	389,740	5,822,969
March 31, 1995	7,594,220	1,010,886	718,236	283,857	5,581,241

Ambulance Service Fees Receivable – Turnover and Days Billings Uncollected

Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for Ambulance Service Fees Receivable was 2.2 times for fiscal 1999/00; 2.5 times for fiscal 1998/99; 2.2 times for fiscal 1997/98. An increase in turnover indicates that Ambulance Service Fees are collected more rapidly.

Days billings uncollected is another indication of the speed of collecting accounts receivable.

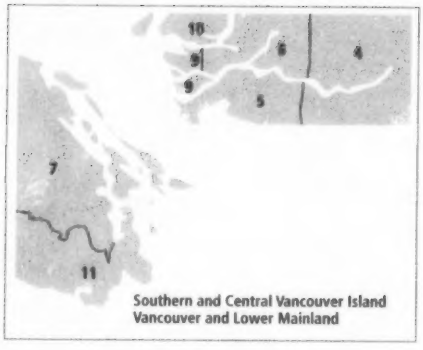
1999/00 – 166 days; 1998/99 – 147 days; 1997/98 – 168 days.

***Collections and Credit Adjustments include all fees paid, and adjustments that reduce indebtedness.*

Collection Program Costs

	1999/00	1998/99	1997/98	1996/97
Collection Dept Costs	$750,000	$750,000	$600,000	$500,000
Collection & Loan Management Branch	155,000	175,758	182,000	–
Collection Agency Commissions	499,666	235,164	195,798	165,295
Total Collection Costs***	**$1,404,666**	**$1,160,922**	**$977,798**	**$665,295**

APPENDIX 7 – REGIONAL HEALTH BOARDS



REGIONAL HEALTH BOARDS

1. North Okanagan
2. Okanagan Similkameen
3. Thompson
4. Fraser Valley
5. South Fraser
6. Simon Fraser
7. Central Vancouver Island
8. Northern Interior
9. Vancouver/Richmond
10. North Shore
11. Capital

Prepared by: Information and Analysis Branch, Ministry of Health and Ministry Responsible for Seniors.
Boundary Source: BC STATS, Ministry of Finance and Corporate Relations.

APPENDIX 8 – COMMUNITY HEALTH COUNCILS

COMMUNITY HEALTH COUNCILS

1. Elk Valley and South Country
2. Cranbrook
3. Kimberley
4. Columbia Valley
5. Creston and District
6. Nelson and Area
7. Castlegar and District
8. Arrow Lakes/Upper Slocan Valley
9. Greater Trail
10. Boundary
11. Golden
12. South Cariboo
13. Central Cariboo Chilcotin
14. Quesnel and District
15. Bella Coola and District Transitional
16. Sunshine Coast
17. Powell River
18. Sea To Sky
19. Comox Valley
20. Campbell River/Nootka
21. Mount Waddington
22. Central Coast Transitional
23. South Peace
24. North Peace
25. Fort Nelson-Liard
26. Bulkley Valley
27. Upper Skeena
28. Terrace and Area
29. Kitimat and Area
30. North Coast
31. Queen Charlotte Islands/Haida Gwaii
32. Nisga'a (not designated under *the Health Authorities Act*)
33. Snow Country
34. Stikine

Prepared by: Information and Analysis Branch, Ministry of Health and Ministry Responsible for Seniors.
Boundary Source: BC STATS, Ministry of Finance and Corporate Relations.

APPENDIX 9 – COMMUNITY HEALTH SERVICES SOCIETIES

COMMUNITY HEALTH SERVICES SOCIETIES

1. East Kootenay
2. Kootenay Boundary
3. Coast Garibaldi
4. Upper Island/Cental Coast
5. Cariboo
6. North West (excludes Nisga'a)
7. Peace Liard

Prepared by: Information and Analysis Branch, Ministry of Health and Ministry Responsible for Seniors
Boundary Source: BC STATS, Ministry of Finance and Corporate Relations